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Niagara District Health Council Conseil régional de santé de Niagara

Niagara's Annual District Service Plan for Long-Term Care Community Services, 2001-2002

➤ An Update to the 1999-2000 Annual Plan

February 21, 2001

Remarque: Le sommaire est également présenté en français dans ce rapport

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EXECUTIVE SUMMARY

Significant progress has been made in improving access and availability of services in Niagara since Niagara's first annual district service plan for long-term care community services was endorsed by Niagara District Health Council in June 1996.

- The Ministry of Health and Long Term Care (MOHLTC) has approved new funding (\$29,981,204 since June 1996) to support enhanced and expanded operations.
- Service providers, consumers and policy makers meet more regularly to discuss issues and plan for improved information sharing and collaboration.
- Information technology needs have begun to be addressed to support the development of an efficient, effective system of service delivery.

Much more needs to be done before community services in Niagara funded by the MOHLTC will be able to meet the steadily growing need for services.

Many health and related support services needed by residents in Niagara continue to be unavailable locally. Access to others is impeded by long wait lists, restrictive eligibility criteria or inadequate resources. Services to support family, friends and other "informal" caregivers remain inadequate to help them cope with the increasing burden of care. The shortage of physicians in Niagara impedes access to primary care management and compounds problems for those needing ongoing care, treatment and support.

The need to support individuals who are on long-term care facility waiting lists but living in the community for lengthy periods (1741 as of November 30, 2000) strains in-home resources. In order to maintain these individuals in the community, professional and support services must be provided on a regular basis. Many individuals who live alone without support from family, friends or neighbours, are at increased risk for falls, hospitalizations and death. Long stays in the community awaiting placement increase these risks.

The availability of in-home care is only one among several services that help make community living a viable option for many seniors. Other services include supportive housing, caregiver respite programs, adult day and night services, geriatric medical and psycho-geriatric assessment and treatment services have been shown to make a significant contribution to the success of community care. However, in Niagara many of these services have long waiting lists or insufficient staff. Some are not available at all or in limited areas of Niagara. So, while community services may work to keep people in the community longer, they are not available or accessible to many Niagara residents.

In March 1999, the provincial Health Services Restructuring Commission (HSRC) released its final directions for restructuring Niagara's hospitals. The HSRC report emphasizes reinvestment must occur in post-hospitalization in-home care and in broader long-term care services in order for hospital restructuring to be successful. By 2003, the HSRC expects the government to reinvest:

- \$6 million for the in-home care of patients following inpatient and same day surgery
- \$28.6 million in additional annual funding for 555 new long-term care beds and 1,387 additional long-term care places in supportive housing, attendant care, adult day care and visiting professional/personal care services.

While the MOHLTC has announced 646 new long term care beds for Niagara and \$12.7 million in new funding for community long-term care services since May of 1999 (including close to \$9 million for the CCAC), it is unclear how many additional "places" Niagara is eligible for to comply with the HSRC directions. At the very least Niagara is eligible to receive close to an additional \$4.8 million, which is the balance of the \$27,300,000 promised by the MOHLTC to further expand and enhance services in Niagara by the year 2006.

Of the 646 new long term care beds, none are operational at the present time, and they are not expected to be fully in place until 2004. Also, of the \$13.1 million in new funding since May of 1999, over half has just recently (September 2000) been allocated and therefore the extent of impact in addressing service needs and gaps is not yet known.

Intercity, Niagara-wide transportation to access services, expanded opportunities for cross-sector training and further collaboration between service providers are fundamental to making services work in Niagara.

This plan makes specific recommendations that the MOHLTC allocate the available balance of close to \$5 million in 2001-2002. It also identifies (where known and/or applicable) funds which will be needed in future to meet identified needs in Niagara, but which could not feasibly be operationalized in fiscal 2001-2002.

Recommended allocations (bracketed numbers and letters refer to MOHLTC codes for services):

Caregiver support: support & counselling services (08A)	\$ 150,000
Caregiver support: respite services (CCAC or 08C)	887,500
Caregiver support: training, education & information (08B)	262,500
Community support services (e.g., MOW, Friendly Visiting, etc.) (02A, 03A, 05C, 06A, 07A)	400,000
Volunteer Transportation (04A)	150,000
Adult day services: seniors (01A-B-C-E)	25,000
Adult day services: ABI (01D)	150,000
Client intervention and assistance (09I)	100,000
Independence training – ABI outreach (09K)	250,000
Independence training – Adults with physical disabilities (09G)	150,000
Homemaking/personal support/attendant/respite: adults with disabilities (12B)	500,000
CCAC services (visiting professional & homemaking, school health) (13A to 20A)	1,000,000
Palliative care services (08D, 24A)	200,000
Special services for the blind and visually impaired (25A)	12,000
	(continued)

Special services for persons with acquired hearing loss (26A)	50,000
Supportive housing services (SHU 11A, SHU 12A, SHU 12D)	300,000
Children's Treatment Centre Services (81A, 82A, 83A, 84A, 88A, 90A, 92A)	<u>\$ 410,000</u>
Sub-total	<u>\$ 4,997,000</u>

PLUS: Additional funding to support the operating costs for full amount of additional long-term care places arising from the restructuring of hospital services in Niagara and recommended by the Health Services Restructuring Commission for supportive housing, homemaking/personal support/attendant/respite services, adult day services and visiting professional services.

The plan also makes several other recommendations critical to the effective, efficient development of community services in Niagara. A listing of all funding and other recommendations follows:

- 3.2.1.1 THAT the MOHLTC allocate adequate funding for LTC facilities to care for higher intensity needs residents and for specialized dementia care
- 3.2.2.1 THAT the MOHLTC pursue development of a regulatory process for rest and retirement homes that will provide an objective assessment of the quality of care and services provided
- 6.1.1 THAT the MOHLTC allocate up to \$150,000 to provide additional caregiver support and counselling services (08A) for individuals caring for people living at home with chronic, degenerative conditions, and allocate the remainder of the outstanding balance to provide respite for families.
- 6.2.1 THAT the MOHLTC review its policy to allow the expansion of paid respite services (08C)
- 6.2.2 THAT the MOHLTC, in the absence of a change in government policy to allow expansion of paid respite, allocate up to \$887,500 to allow the CCAC to provide respite services over and above the maximum allowable hours.
- 6.3.1 THAT the MOHLTC allocate up to \$262,500 to provide expanded caregiver support training, information and education services (08B) for individuals living at home with chronic, degenerative conditions.
- 6.4.1 THAT the MOHLTC allocate up to \$ 400,000 to provide additional community support services, including meal services, friendly visiting, security checks and home maintenance and repair.
- 6.4.2 THAT the MOHLTC support the collaborative efforts of the two member agencies of Meals on Wheels/Community Support Services and encourage remaining four meals on wheels agencies to integrate in order to provide consistent community support services in all areas of Niagara for elderly people and others requiring such services.

- 6.4.3 THAT the MOHLTC allocate up to \$150,000 to provide additional volunteer transportation services to children, elderly people and others with mobility impairments requiring such services.
- 6.4.4 THAT Niagara DHC staff continue to support the efforts of Mobility Niagara to develop a revised business plan and, as appropriate, to secure the necessary funding (e.g., from municipalities, provincial government, etc.) to resume operations.
- 6.4.5 THAT the MOHLTC support a non-ambulance transportation pilot project in Niagara for possible extension as a model in the province.
- 6.4.6 THAT the MOHLTC review its policy and consider including paid transportation as a long-term care community services category eligible for funding.
- 6.5.1 THAT the MOHLTC allocate up to \$25,000 to implement a pilot project for an adult day service for palliative care clients.
- 6.6.1 THAT the MOHLTC, allocate up to \$150,000 to develop and support funded adult day services (01D) for people with acquired brain injuries living in Niagara, with transportation included in the per diem rate.
- 6.7.1 THAT the MOHLTC allocate up to \$250,000 to provide additional Independence Training - ABI outreach services (09K) to individuals with acquired brain injuries in Niagara.
- 6.7.2 THAT the MOHLTC allocate up to \$150,000 to provide Independence Training for adults with physical disabilities in Niagara (09G)
- 6.8.1 THAT the MOHLTC and Niagara DHC share this plan with the two Friendship Centres in Niagara and the Welland Metis Council and work with them as appropriate on issues associated with accessing mainstream long-term care services and need for culturally-sensitive services.
- 6.9.1 THAT the MOHLTC allocate additional funding of up to \$100,000 to operationalize the new Gatekeepers model in Niagara
- 6.9.2 THAT the Long Term Care Committee continue to work with the Community Services Department/Gatekeepers Program to monitor service volumes and trends with respect to Client Intervention and assistance
- 6.10.1 THAT the MOHLTC, allocate up to \$500,000 to expand and enhance homemaking/personal support/attendant respite (adults with disabilities) service (12B) in Niagara to (partially) meet the needs of those on the wait list for service.

- 6.12.1 THAT the MOHLTC continue to publicize the availability of the self-managed attendant service and identify organizations in communities across Ontario to respond to questions from interested people and support individuals in accessing the service.
- 6.13.1 THAT the MOHLTC allocate the full amount of funding identified by the Health Services Restructuring Commission (HSRC) in its final report on Niagara. Specifically, allocate additional funding needed to provide in-home long-term care and support "places" consistent with HSRC directions.
- 6.13.2 THAT the MOHLTC allocate \$500,000 to the CCAC for a pilot project specifically to serve the frail elderly, to improve their quality of life in their own homes.
- 6.13.3 THAT the MOHLTC review CCAC School Health Support Services and allocate up to \$500,000 to begin to address the very large wait list for services.
- 6.14.1 THAT the MOHLTC allocate up to \$200,000 to provide additional palliative care services consistent with the balance of previous funding recommendations remaining unallocated for each defined service (08D, 24A).
- 6.14.2 THAT the MOHLTC proceed quickly to identify a policy framework within the MOHLTC to support the funding and operation of residential hospices to meet the growing need for alternative approaches to caring for persons living with a terminal illness who do not need treatment in a hospital setting
- 6.14.3 THAT the Niagara DHC work in conjunction with Hospice Niagara to assess the need for Day Hospice Services in Niagara. Include in this analysis the fit between day hospice and adult day services as currently defined by the MOHLTC and focus group discussions to be held in early 2001.
- 6.14.4 THAT the Niagara DHC work with existing palliative and cancer care services in Niagara to determine how the new Wellspring Niagara cancer support service fits into the spectrum of services.
- 6.16.1 THAT the MOHLTC allocate up to \$12,000 to support further expansion of special services for the blind and visually impaired (25A) to meet the growing need for services for the blind and visually impaired.
- 6.17.1 THAT the MOHLTC allocate up to \$50,000 to meet growing demands for services for people with acquired hearing loss.
- 6.18.1 THAT the MOHLTC allocate up to \$300,000 to expand and enhance the availability of supportive housing services for seniors (SHU 11A), adults with disabilities (SHU 12A) and people with acquired brain injuries (SHU 12D).

- 6.18.2 THAT the MOHLTC identify a policy framework within the MOHLTC to support the funding and operation of residential services to meet the needs of persons with acquired brain injuries who are minimally responsive to external stimuli (e.g., proposal from Headway Homes)
- 6.18.3 THAT the MOHLTC provide capital funding and government policy support to build and/or renovate accessible, subsidized housing units for seniors, people with physical disabilities, and adults with acquired brain injuries.
- 6.18.4 THAT the MOHLTC support AIDS Niagara in working with other agencies in Niagara to help staff meet the particular needs of residents receiving supportive housing services.
- 6.19.1 THAT the MOHLTC allocate up to \$250,000 to meet the serious service pressures and long waits for services being experienced by children with physical or communicative disabilities.
- 6.19.2 THAT the MOHLTC review its policy and allocate up to \$160,000 for the Niagara Peninsula Children's Centre to resume and expand augmentative communication services for adults.
- 6.20.1 THAT the MOHLTC continue its review of the managed competition model.
- 6.20.2 THAT the MOHLTC support the need for additional emphasis on and additional training places for professional and community support service providers to meet expanding needs.
- 6.20.3 THAT the Long Term Care Committee proceed with assessing the issues associated with managed competition as well as the extent of human resource shortages at the local level.
- 6.21.1 THAT the MOHLTC fund services requiring comparatively smaller funding allocations of \$100,000 or less, specifically:
- client intervention and assistance (Rec. 6.9.1);
 - adult day services for terminally ill clients (Rec. 6.5.1);
 - services for the blind and visually impaired (Rec. 6.16.1); and,
 - services for persons with acquired hearing loss (Rec. 6.17.1).
- 6.21.2 THAT the MOHLTC give priority to the urgent need to address the following:
- transportation, both volunteer and alternative models (Recs. 6.4.3, 6.4.5 and 6.4.6);
 - caregiver respite services through paid services or protected CCAC services (Recs. 6.2.1 and 6.2.2); and,
 - CCAC services, especially for the frail elderly and school health support services (Recs. 6.13.2 and 6.13.3).

SOMMAIRE

Au mois de juin 1996, le Conseil régional de santé de Niagara avait approuvé le premier plan de services annuel de district pour les services communautaires de soins de longue durée de Niagara.

Depuis ce temps, des progrès considérables ont été réalisés par rapport à l'accessibilité et à la disponibilité des services à Niagara.

- Le ministère de la Santé et des Soins de longue durée (MSSLD) a approuvé des fonds supplémentaires (soit 29 981 204 \$ depuis juin 1996) visant à favoriser l'amélioration et l'élargissement des activités.
- Les prestataires de services, les usagers et les décideurs se réunissent plus régulièrement afin de discuter des enjeux et de planifier l'amélioration de la collaboration et du partage d'information.
- On a commencé à se pencher sur les besoins en matière de technologie de l'information afin de favoriser l'instauration d'un système de prestation de services efficient et efficace.

Il reste encore beaucoup de travail à abattre avant que les services communautaires à Niagara qui sont financés par le MSSLD ne soient en mesure de satisfaire à la demande croissante de services.

Bon nombre des services de santé et des services de soutien connexes dont les résidents de Niagara ont besoin ne sont toujours pas offerts à l'échelle locale. Les longues listes d'attente, les critères d'admissibilité restrictifs ou le manque de ressources adéquates font obstacle à l'accès à d'autres genres de services. Les services de soutien aux familles, aux amis et à d'autres soignants naturels ne suffisent toujours pas à aider ces groupes à faire face au fardeau de soins croissant. De plus, la pénurie de médecins qui sévit à Niagara entrave l'accès à la gestion des soins primaires et contribue à multiplier les problèmes chez les personnes ayant besoin de soins, de traitement et de soutien continus.

Le besoin d'assurer des services de soutien pendant de longues périodes aux personnes qui sont inscrites sur les listes d'attente d'établissements de soins de longue durée mais qui vivent dans la communauté (1 741 personnes en date du 30 novembre 2000) pèse lourdement sur les ressources à domicile. Pour que ces personnes puissent rester dans la communauté, il faut leur fournir des services professionnels et des services de soutien de façon régulière. Bon nombre de gens vivant seuls, sans l'appui de leur famille, d'amis ou de voisins, s'exposent davantage aux risques de chute, d'hospitalisation et de décès. Ces risques augmentent lorsque les gens doivent attendre longtemps avant d'être placés dans un établissement.

Les soins à domicile, entre plusieurs autres services, offrent à de nombreuses personnes âgées un moyen viable de vivre en milieu communautaire. Il a été démontré que d'autres services, notamment le logement avec services de soutien, les programmes de relève pour soignants, les services de jour et de nuit pour adultes ainsi que les services d'évaluation et de traitement médicaux et psychologiques en gériatrie, contribuent considérablement au succès des soins communautaires. Toutefois, à Niagara, bon nombre de ces services ont de longues listes d'attente ou ne disposent pas

d'un nombre suffisant d'employés. De plus, certains de ces services sont inexistantes ou ne sont offerts que dans certaines régions de Niagara. Ainsi, bien que les services communautaires puissent contribuer à permettre aux gens de rester dans la communauté plus longtemps, ils ne sont pas offerts ou accessibles à de nombreux résidents de Niagara.

Au mois de mars 1999, la Commission de restructuration des services de santé (CRSS) a publié ses directives définitives concernant la restructuration des hôpitaux de Niagara. Dans son rapport, la CRSS souligne qu'afin d'assurer le succès de la restructuration des hôpitaux, il faut réinvestir dans les soins à domicile post-hospitaliers ainsi que dans les services de soins de longue durée en général. D'ici l'an 2003, la CRSS s'attend à ce que le gouvernement réinvestisse les sommes suivantes :

- 6 millions de dollars dans les soins à domicile offerts aux personnes qui ont été hospitalisées ou qui ont subi une chirurgie d'un jour;
- 28,6 millions de dollars en fonds annuels supplémentaires pour créer 555 nouveaux lits de soins de longue durée et 1 387 places additionnelles pour les soins de longue durée dans les domaines suivants : logements avec services de soutien, soins auxiliaires, soins de jour pour adultes et visites de travailleurs offrant des services professionnels et des services de soins personnels.

Bien que le MSSLD ait annoncé la création de 646 nouveaux lits de soins de longue durée pour Niagara et l'affectation de 12,7 millions de dollars en fonds nouveaux aux services communautaires de soins de longue durée depuis le mois de mai 1999 (y compris près de 9 millions de dollars pour les CASC), on ne peut préciser le nombre de « places » additionnelles auquel la région de Niagara a droit en vertu des directives de la CRSS. Tout au moins, Niagara pourrait recevoir près de 4,8 millions de dollars supplémentaires, ce qui représente le reste des 27 300 000 \$ que le MSSLD a promis pour élargir et améliorer les services offerts à Niagara d'ici l'an 2006.

Parmi les 646 nouveaux lits de soins de longue durée, aucun n'est présentement fonctionnel. De fait, on ne s'attend pas à ce que ces lits soient en place avant l'an 2004. De plus, des 13,1 millions de dollars accordés depuis mai 1999, plus de la moitié viennent tout juste (septembre 2000) d'être affectés. On ne connaît donc pas encore la mesure dans laquelle les besoins et les lacunes en matière de services ont été comblés.

Pour que la prestation de services soit efficace à Niagara, il faut assurer des services de transport qui permettront l'accès aux services dans toute la région de Niagara, offrir davantage de possibilités de formation intersectorielle et favoriser la collaboration entre les prestataires de services.

Le plan recommande tout particulièrement que le MSSLD affecte les quelque 5 000 000 \$ qui restent en 2001-2002. Il précise également les sommes qui seront nécessaires à l'avenir pour répondre aux besoins relevés à Niagara, mais dont l'utilisation n'était pas possible au cours de l'exercice financier 2001-2002.

Allocations recommandées (les chiffres et les lettres entre parenthèses correspondent aux codes de services du MSSLD) :

Soutien aux aidants : services de soutien et de counseling (08A)	150 000 \$
Soutien aux aidants : services de relève (CASC ou 08C)	887 500
Soutien aux aidants : formation, éducation et information (08B)	262 500
Services de soutien communautaires (p. ex. : repas livrés à domicile, visites amicales, etc.) (02A, 03A, 05C, 06A, 07A)	400 000
Transport par des bénévoles (04A)	150 000
Services de jour pour adultes : personnes âgées (01A-B-C-E)	25 000
Services de jour pour adultes : traumatismes crâniens (01D)	150 000
Intervention et assistance auprès des clients (09I)	100 000
Formation à l'autonomie fonctionnelle : traumatismes crâniens – services d'approche (09K)	250 000
Formation à l'autonomie fonctionnelle – adultes ayant un handicap physique (09G)	150 000
Aide familiale/soutien personnel/soins auxiliaires/soins de relève – adultes ayant un handicap physique (12B)	500 000
Services du CASC : visites de travailleurs offrant des services professionnels, aide familiale, santé à l'école (13A à 20A)	1 000 000
Services de soins palliatifs (08D, 24A)	200 000
Services spéciaux pour aveugles et personnes ayant un handicap visuel (25A)	12 000
Services spéciaux pour personnes ayant une déficience auditive acquise (26A)	50 000
Logements avec services de soutien (SHU 11A, SHU 12A, SHU 12D)	300 000
Centres de traitement des enfants (81A, 82A, 83A, 84A, 88A, 90A, 92A)	410 000
Sous-total	4 997 000 \$

EN SUS : Des fonds additionnels pour aider à couvrir les coûts d'exploitation associés à l'ensemble des places supplémentaires pour les soins de longue durée qui découlent de la restructuration des services hospitaliers à Niagara et qui ont été recommandées par la Commission de restructuration des services de santé dans les secteurs suivants : logements avec services de soutien, aide familiale/soutien personnel/soins auxiliaires/services de relève, services de jour pour adultes et visites de travailleurs offrant des services professionnels.

Le plan contient aussi plusieurs recommandations indispensables à l'instauration efficace et efficiente de services communautaires à Niagara. Une liste de toutes les recommandations, y compris celles en matière de financement, figure ci-dessous :

3.2.1.1 QUE le MSSLD alloue aux établissements de SLD les fonds dont ils ont besoin pour s'occuper des personnes ayant des besoins intensifs ainsi que des personnes atteintes de démence ayant besoin de soins spécialisés.

- 3.2.2.1 QUE le MSSLD établisse un processus de réglementation pour les maisons de repos et de retraite qui permettra d'évaluer objectivement la qualité des soins et des services fournis.
- 6.1.1 QUE le MSSLD alloue jusqu'à 150 000 \$ pour fournir des services de soutien et de counseling supplémentaires aux aidants (08A) qui s'occupent de personnes vivant à la maison et ayant des maladies chroniques et dégénératives, et qu'il alloue le reste des fonds aux services de relève pour les familles.
- 6.2.1 QUE le MSSLD mette au point sa politique afin de permettre l'élargissement des services de relève payés (08C).
- 6.2.2 QUE le MSSLD alloue, en l'absence d'une nouvelle politique gouvernementale permettant l'élargissement des services de relève payés, jusqu'à 887 500 \$ pour permettre au CASC d'offrir des services de relève au-delà du nombre maximal d'heures alloué.
- 6.3.1 QUE le MSSLD alloue jusqu'à 262 500 \$ à l'élargissement des services de formation, d'information et d'éducation pour les aidants (08B) qui s'occupent de personnes vivant à la maison et ayant des maladies chroniques et dégénératives.
- 6.4.1 QUE le MSSLD alloue jusqu'à 400 000 \$ pour fournir des services de soutien communautaires additionnels, y compris des services de repas, des visites amicales, des vérifications de sécurité et des services d'entretien ménager et de réparations.
- 6.4.2 QUE le MSSLD appuie les efforts de collaboration déployés par les deux organismes membres de Popote roulante/Services de soutien communautaires, et qu'il encourage les quatre autres organismes de livraison de repas à domicile à s'intégrer de manière à offrir dans toutes les régions de Niagara des services de soutien communautaires uniformes à l'intention des personnes âgées et d'autres personnes nécessitant de tels services.
- 6.4.3 QUE le MSSLD alloue jusqu'à 150 000 \$ pour augmenter les services de transport offerts par des bénévoles aux enfants, aux personnes âgées et à d'autres personnes ayant une déficience motrice et nécessitant de tels services.
- 6.4.4 QUE le personnel du CRS de Niagara continue d'appuyer les efforts déployés par Mobility Niagara pour élaborer un plan d'activités révisé et, au besoin, obtenir les fonds nécessaires (p. ex. : auprès des municipalités, du gouvernement provincial, etc.) à la reprise des activités.
- 6.4.5 QUE le MSSLD appuie un projet-pilote de transport non ambulancier à Niagara qui pourrait éventuellement servir de modèle à l'échelle de la province.
- 6.4.6 QUE le MSSLD mette au point sa politique et considère y inclure le transport payé comme une catégorie de services communautaires de soins de longue durée admissible au financement.

- 6.5.1 QUE le MSSLD alloue jusqu'à 25 000 \$ à la mise en oeuvre d'un projet-pilote visant un service de jour pour adultes à l'intention des clients recevant des soins palliatifs.
- 6.6.1 QUE le MSSLD alloue jusqu'à 150 000 \$ pour élaborer et appuyer des services de jour pour adultes subventionnés (01D) à l'intention des personnes ayant subi des traumatismes crâniens et vivant à Niagara (le transport étant inclus dans le taux quotidien).
- 6.7.1 QUE le MSSLD alloue jusqu'à 250 000 \$ pour fournir des services additionnels de formation à l'autonomie fonctionnelle – services d'approche (09K) aux personnes ayant subi un traumatisme crânien à Niagara.
- 6.7.2 QUE le MSSLD alloue jusqu'à 150 000 \$ pour fournir des services de formation à l'autonomie fonctionnelle aux personnes ayant un handicap physique (09G) à Niagara.
- 6.8.1 QUE le MSSLD et le CRS de Niagara partage ce plan avec les deux Friendship Centres à Niagara et le Welland Metis Council et qu'ils se penchent avec eux, lorsqu'ils le jugent approprié, sur des questions touchant l'accès aux services de soins de longue durée courants et le besoin de services adaptés aux différences culturelles.
- 6.9.1 QUE le MSSLD alloue des fonds supplémentaires allant jusqu'à 100 000 \$ afin de rendre opérationnel le nouveau modèle Gatekeepers à Niagara.
- 6.9.2 QUE le Comité des soins de longue durée continue de collaborer avec les Services communautaires/le programme Gatekeepers afin de surveiller les volumes et les tendances en matière de services pour ce qui est de l'intervention et de l'assistance auprès des clients.
- 6.10.1 QUE le MSSLD alloue jusqu'à 500 000 \$ pour agrandir et améliorer les services d'aide familiale/de soutien personnel/d'auxiliaires/de relève (adultes ayant un handicap physique – 12B) à Niagara afin de répondre (en partie) aux besoins des personnes sur la liste d'attente.
- 6.12.1 QUE le MSSLD continue d'annoncer la disponibilité du service d'auxiliaires auto-géré et qu'il désigne des organismes dans les communautés partout en Ontario pour répondre aux questions posées par les personnes intéressées et aider les gens à accéder à ce service.
- 6.13.1 QUE le MSSLD alloue l'intégralité du financement indiqué par la Commission de restructuration des services de santé (CRSS) dans son rapport final sur les services offerts à Niagara. Plus particulièrement, il est recommandé que le MSSLD alloue les fonds additionnels nécessaires pour fournir des soins de longue durée à domicile et permettre la création de « places » additionnelles pour les soins de longue durée, conformément aux directives de la CRSS.
- 6.13.2 QUE le MSSLD alloue 500 000 \$ au CASC pour lui permettre de mener un projet-pilote visant à améliorer la qualité de vie des personnes âgées frêles dans leurs propres domiciles.

- 6.13.3 QUE le MSSLD mette au point les services auxiliaires de santé dans les écoles du CASC et qu'il alloue jusqu'à 500 000 \$ pour commencer à se pencher sur la question des longues listes d'attente.
- 6.14.1 QUE le MSSLD alloue jusqu'à 200 000 \$ pour fournir des services de soins palliatifs supplémentaires en fonction des sommes qui avaient été prévues dans les recommandations antérieures, mais qui n'ont pas été allouées pour chaque service défini (08D, 24A).
- 6.14.2 QUE le MSSLD procède rapidement à l'établissement d'un cadre de politique pour appuyer le financement et l'exploitation d'hospices résidentiels en vue de répondre au besoin croissant de trouver de nouvelles façons de s'occuper des malades en phase terminale qui n'ont pas besoin de traitements en milieu hospitalier.
- 6.14.3 QUE le CRS de Niagara collabore avec Hospice Niagara afin d'évaluer le besoin de services d'hospice de jour à Niagara. Que le CRS de Niagara inclut dans cette analyse une explication sur la façon dont les services d'hospice de jour cadrent avec les services de jour pour adultes, comme ils sont définis par le MSSLD, de même que les résultats des groupes de discussions prévus pour le début de 2001.
- 6.14.4 QUE le CRS de Niagara collabore avec les services actuels de soins palliatifs et de soins pour les personnes atteintes du cancer à Niagara afin de déterminer dans quelle mesure le nouveau service de soutien pour les personnes atteintes du cancer, soit Wellspring Niagara, cadre avec la gamme de services.
- 6.16.1 QUE le MSSLD alloue jusqu'à 12 000 \$ pour financer l'élargissement des services spéciaux pour les aveugles et les personnes ayant un handicap visuel (25A) afin de répondre au besoin croissant de ce groupe en matière de services.
- 6.17.1 QUE le MSSLD alloue jusqu'à 50 000 \$ pour satisfaire la demande croissante de services pour les personnes ayant une déficience auditive acquise.
- 6.18.1 QUE le MSSLD alloue jusqu'à 300 000 \$ pour augmenter et améliorer le logement avec services de soutien pour les personnes âgées (SHU 11A), les adultes ayant un handicap physique (SHU 12A) et les personnes ayant subi un traumatisme crânien (SHU 12D).
- 6.18.2 QUE le MSSLD établisse un cadre de politique pour appuyer le financement et l'exploitation de services résidentiels en vue de répondre aux besoins des personnes qui ont subi un traumatisme crânien et qui réagissent très peu au stimulus externe (p. ex. : proposition de Headway Homes).
- 6.18.3 QUE le MSSLD fournisse des fonds pour dépenses en capital et établisse des politiques gouvernementales pour permettre la construction ou la rénovation de logements subventionnés accessibles pour les personnes âgées, les personnes ayant un handicap physique et les personnes ayant subi un traumatisme crânien.

- 6.18.4 QUE le MSSLD appuie AIDS Niagara dans le travail qu'il accomplit avec d'autres organismes à Niagara afin d'aider le personnel à répondre aux besoins particuliers des résidents qui vivent dans un logement avec services de soutien.
- 6.19.1 QUE le MSSLD alloue jusqu'à 250 000 \$ afin d'alléger les pressions considérables exercées sur les services destinés aux enfants ayant des déficiences physiques ou des troubles de communication et de réduire les longues périodes d'attente pour ces services.
- 6.19.2 QUE le MSSLD mette au point sa politique et alloue jusqu'à 160 000 \$ au Centre pour enfants de la péninsule du Niagara pour lui permettre de poursuivre et d'élargir ses services de suppléance à la communication pour adultes.
- 6.20.1 QUE le MSSLD continue d'examiner le modèle de concurrence dirigée.
- 6.20.2 QUE le MSSLD appuie le besoin de mettre davantage l'accent sur les prestataires de services professionnels et de services de soutien communautaires et d'en former un plus grand nombre afin de leur permettre de répondre aux besoins croissants.
- 6.20.3 QUE le Comité des soins de longue durée évalue les questions associées à la concurrence dirigée et l'ampleur de la pénurie de ressources humaines à l'échelle locale.
- 6.21.1 QUE le MSSLD finance les services ayant besoin de sommes relativement plus petites, soit 100 000 \$ ou moins, notamment :
- les services d'intervention et d'assistance aux clients (rec. 6.9.1);
 - les services de jour pour adultes destinés aux malades en phase terminale (rec. 6.5.1);
 - les services pour aveugles et personnes ayant un handicap visuel (rec. 6.16.1);
 - les services pour personnes ayant une déficience auditive acquise (rec. 6.17.1).
- 6.21.2 QUE le MSSLD accorde la priorité au besoin urgent de se pencher sur les questions suivantes :
- transport : bénévoles et autres modèles (rec. 6.4.3, 6.4.5 et 6.4.6);
 - services de relève pour les aidants – services payés ou services protégés du CASC (rec. 6.2.1 et 6.2.2);
 - services offerts par le CASC, particulièrement les services offerts aux personnes âgées frêles et les services auxiliaires de santé dans les écoles (rec. 6.13.2 et 6.13.3).

1 SERVICE PLAN DEVELOPMENT

The purpose of this section is to summarize the process followed in updating the 1999-2000 Annual District Service Plan for Niagara 2001-2002.

This fifth annual district service plan has been developed by Niagara District Health Council's Long-Term Care Committee (see membership list in Appendix A).

In preparing this update of the 1999-2000 annual district service plan, the Committee considered information from various sources:

- recent provincial funding allocations for the enhancement and/or expansion of long-term care community services in Niagara
- detailed analyses of 1999-2000 and 2000-2001 annual service plans prepared by organizations funded in Niagara to provide long-term care community services
- demographic information from the 1996 Census
- results of a consultation survey sent to approximately 200 long term care community agencies and consumer groups, mental health agencies and consumer groups, physicians, hospitals, long term care facilities and rest and retirement homes.

This updated plan follows the format proscribed by the Ministry of Health and Long-Term Care (MOHLTC). Portions of the parent document, the 1999-2000 ADSP, have been retained or summarized to aid in the understanding of the document and to put new information in context.

2 ENVIRONMENTAL SCAN

This section provides an update only on the profile of the Niagara community. It includes a demographic summary based on the 1996 census (using adjusted figures, whereas the 1999-2000 plan used unadjusted figures) and Ministry of Finance population projections. It also includes an update on consumer needs and an updated summary of trends and key service delivery challenges as reported by community long term care agencies in their Agency Service Plans and through the more inclusive? wider? consultation process described in the previous section.

2.1 Geographic Location, Boundaries, Size and Distribution of Population

The Niagara region is an eighteen hundred and fifty (1850) square kilometre area defined by its natural borders: Lake Ontario on the north, the Niagara River on the east and Lake Erie on the south.

Only the western boundary is less well-defined as it borders on farmland which extends into other political areas (Haldimand-Norfolk and Hamilton-Wentworth). Niagara contains twelve local municipalities: five cities, five towns and two townships. It is a mixture of urban areas, small towns and hamlets, and large agricultural rural areas. Geographic divisions, formed long before Niagara became a regional municipality, continue to influence the organization and delivery of all human services.

Two major transportation corridors cut through Niagara. Running along and below the northern edge of the Niagara escarpment, the QEW slices through several of the region's municipalities from Grimsby in the west to Fort Erie in the east where it meets the US border. At the border, the highway connects with major land transportation arteries in the United States. The Welland Canal cuts across the peninsula from north to south. An essential shipping link between the St. Lawrence Seaway, Lake Ontario and Lake Erie, the canal is a busy waterway dividing communities in the east of Niagara from those in the west.

There is no regional transportation system to link the various communities within Niagara. Three municipalities (St. Catharines, Welland and Niagara Falls) offer a regular and a specialized transportation service within their municipal boundaries (see Section 6.4 for further discussion on transportation).

While no single local municipality contains a majority of Niagara's residents, the more rural municipalities contain just over one-third of the region's current total population of about 420,000 (see Figure 2.1a). According to the 1996 census, St. Catharines is home to about 32% of the population, Niagara Falls about 19% and Welland about 12% (see Figure 2.1b).

FIGURE 2.1a

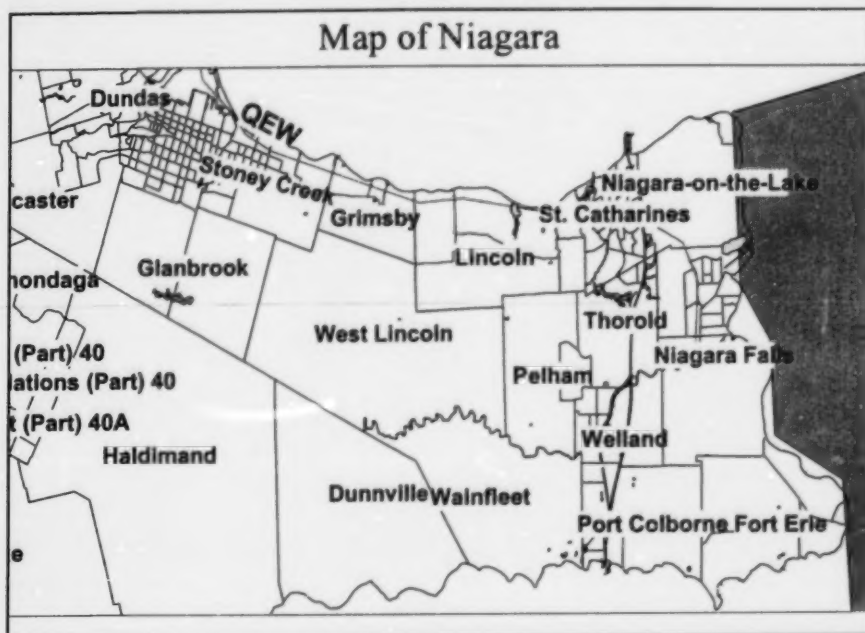
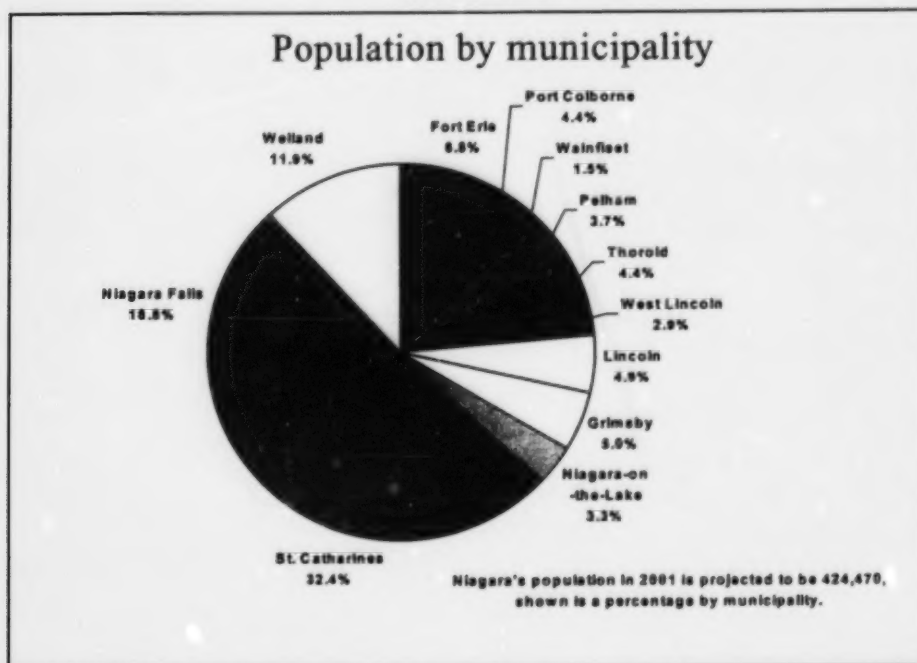


FIGURE 2.1b



The municipalities of Welland and Port Colborne are designated communities under the French Language Services Act.

Niagara's climate, location and geographic features make it attractive to older adults for retirement living. However, its long-term economic slowdown coupled with its large agricultural sector have contributed to a significant migration of younger persons from the area. In 1996, this trend is obvious by Niagara's lower than provincial average for age ranges of 0-50 yrs and higher than provincial average for age ranges 50+. As a consequence, Niagara has a large concentration of seniors. According to the 1996 census, persons age 65 and over constitute 16.32% of Niagara's population. This compares to the 1996 provincial average of 12.6% (see Figures 2.1c and 2.1d).

FIGURE 2.1c

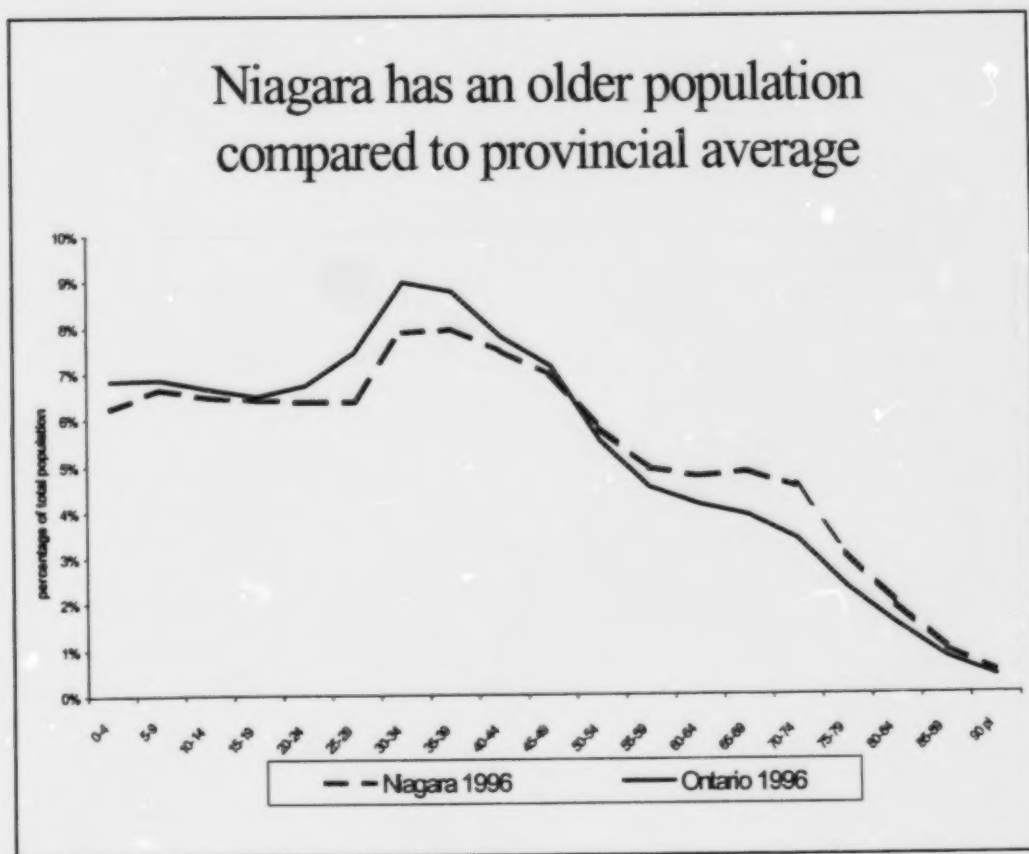
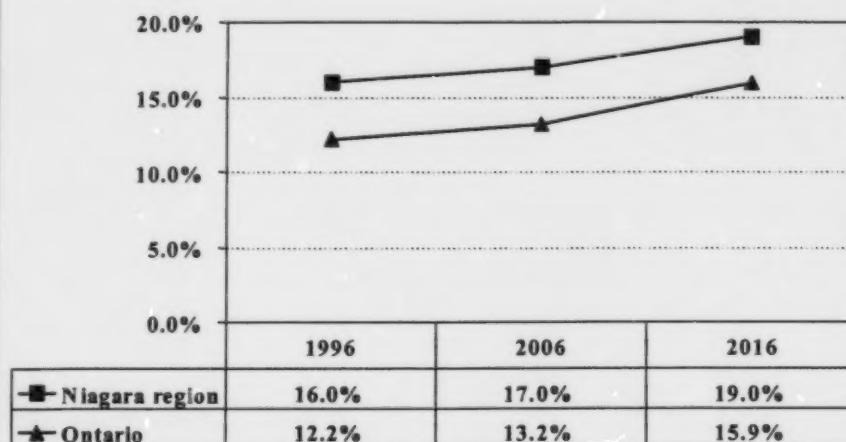


FIGURE 2.1d

The proportion of the population aged 65+, Niagara and Ontario, in 1996 and projected for 2016



The province reaches a comparable proportion of senior's 65+ by year 2016 with 15.9%, yet Niagara will continue to grow among this age category to a record 19% by 2016. Niagara's aging trend continues through 2016 where the population declines among ages 0-44 years, but continues to mirror the provincial growth among older age categories.

FIGURE 2.1e

Projected population growth, Niagara and Ontario, by age group, 1996-2016

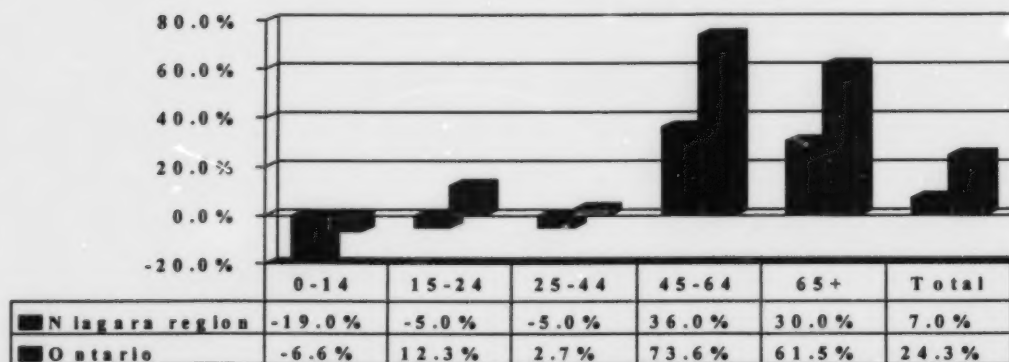


FIGURE 2.1f
Older age groups growing at a rapid rate in Niagara, 1996-2016

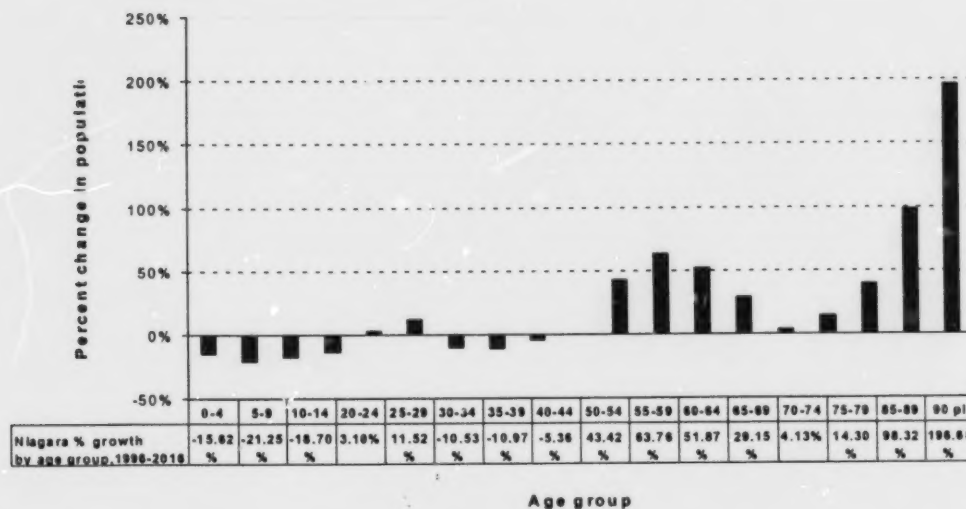
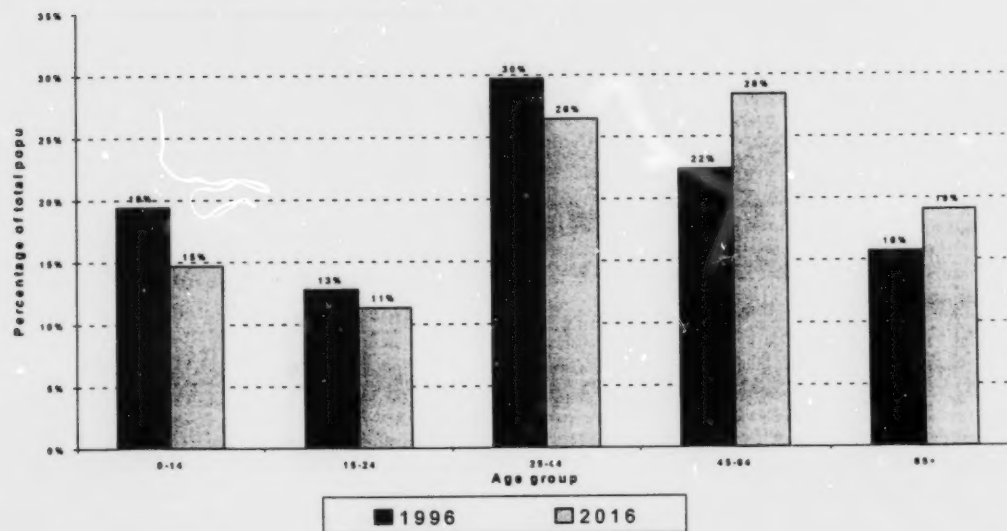


FIGURE 2.1g
Current and projected population by age group, as a % of total population of Niagara



By 2006 Niagara's population aged 75 and over will have grown 16.6% to 37,369 and the population aged 85 and over will have grown more than 32.8% to 9,899 people. By 2011, Niagara will have enough people aged 65 and older to completely fill a city equivalent to the size of Niagara Falls today; and, every second person in that city will be age 75 or older. Appendix B includes population break downs for each municipality in Niagara and population projections for 2003, 2006 and 2011.

2.2 Consumer Needs

The 1999-2000 ADSP provided a list of needs of different population groups living in communities throughout Niagara which were not adequately met. Despite an infusion of a significant amount of new funding over the past 18 months, community stakeholders have confirmed these needs still exist and have provided input on additional needs (highlighted in bold) of these various population groups. It is not known at this time the extent to which these needs will be met once all the new funding has been operationalized.

The reader is cautioned that these needs are not in any priority order nor are they intended to identify all unmet needs. It is noteworthy that transportation has been added to each list, as a seriously unmet area of need in Niagara.

Children

- consistent care from local professionals skilled and knowledgeable about paediatric health and related problems
- appropriate in-home services arranged before discharge from hospital settings
- assurance of effective communication and coordination of services between various provider organizations (regardless of funding sources)
- information, education and support for parents and other informal caregivers to access needed services and to cope with physical, emotional, psycho-social and spiritual issues
- timely access to specialized assessment and treatment services (e.g., speech & language therapy, education, assistive devices & equipment, physiotherapy, occupational therapy, etc.)
- need accessible transportation
- after-school programs for children with special needs who are dealing with physical, social and self-esteem issues

Seniors

- crisis intervention and assistance (including situations of elder abuse)
- client intervention and assistance for vulnerable/at risk seniors
- intensive case management support
- primary, secondary and tertiary mental health assessment, care and treatment
- specialized geriatric assessment, care and treatment services (e.g., for falls, continence, poly-pharmacy, dementia, delirium, depression)
- supportive housing services
- comparable access to community support services across Niagara (e.g., five day a week meal service, friendly visiting, escorted transportation, home maintenance & repair services, etc.)

- equitable access to adult day services, at least 5 days/week, including rural areas of Niagara
- access to professional services at Adult Day Program sites
- accessibility of services both from physical and communicative standpoint
- accessible, intermunicipal transportation
- personal support and single-service homemaking
- specialized, slow-stream rehabilitation services
- access to a full continuum of respite services (e.g., in-home, adult day care, facility and hospital-based respite)
- seamless, consistent support from care providers
- financial assistance for low-income seniors for health devices (e.g., dental services/devices, glasses)

People with physical disabilities

- barrier free access to services (including physical and communicative accessibility)
- affordable, accessible housing units
- supportive housing services
- consistent care and support from skilled individuals with the training and knowledge to help cope with physical, functional and non-medical issues
- support in meeting psycho-social, emotional and spiritual needs
- financial supports to acquire appropriate assistive devices and equipment
- information, referral and support to access needed health, social, employment, recreational and transportation services
- timely access to assessment and treatment
- assurance of effective communication and coordination of services between various health and social service providers
- accessible, affordable transportation (many on fixed incomes)
- assistance to adults with disabilities with child care and parenting responsibilities

Persons with complex care needs

(e.g., people with brain-injuries; people with multiple medical, functional, and/or psycho-social problems, people living with a terminal illness, etc.)

- residential services (e.g., supportive housing, hospice, etc.)
- consistent, specialized visiting professional services (e.g., nursing, physiotherapy, occupational therapy, social work, etc.)
- hospital and institutional services (e.g., transition-to-independent living spaces, specialized diagnostic and treatment services, complex continuing care beds, etc.)
- locally accessible specialized rehabilitation services (e.g., post-acute long term spinal cord injuries, amputee program, augmentative communication services, seating clinics, etc.)
- care from volunteers, professionals and others with appropriately specialized skills and understanding
- information, education and training to maintain or improve functional abilities and to cope with physical, psycho-social, spiritual and emotional concerns
- assurance of effective communication and coordination of needed services from all providers involved with care and treatment (regardless of funding sources)

- access to full range of respite services (in-home, adult day services, facility and hospital-based respite)
- accessible, affordable transportation
- staff training and resources to meet complex care requirements of clients in community settings (e.g., adult day care, supportive housing)
- chronic disease maintenance programs on outreach basis (e.g., congestive heart failure, chronic obstructive pulmonary disease)
- coordinated stroke strategy

Caregivers

- planned respite services (both short and long term in the home and outside the home, day and night; and including short-stay beds in long-term care facilities, rest and retirement homes, and hospitals)
- unplanned and emergency or crisis respite (in homes and in facilities)
- respite service availability overnights, weekends, for extended shifts
- respite services provided by skilled staff for caregivers of clients with advanced dementia
- information, education and training to help deal with specific functional, physical, emotional and behavioural issues in the home
- support and counselling to cope with stress, spiritual, psycho-social and relationship concerns
- information, referral and support in accessing needed services

2.3 Trends and Key Service Delivery Challenges

Organizations funded by the MOHLTC to provide defined long-term care community services in Niagara identified a wide range of trends and challenges in their 1998-99 service plans. Members of Council's Long-Term Care Advisory Committee reviewed the comments and summarized them.

Key Trends

- increased age, frailty of clients, poorer mobility and greater isolation, including a sense there are more elderly living alone in the community
- increasing numbers of consumers with multiple, complex service requirements
- changing family structures which challenge the ability of family members to serve as caregivers (e.g., issues of work, children, spouses, financial support, time constraints)
- increased numbers of clients with dementia living in the community
- earlier discharge from hospitals and less access to beds
- increased awareness, use and expectation of service
- growing collaboration among service providers and more effective coordination of services
- wait lists becoming more prevalent, resulting in services not being provided in a timely fashion

Key Service Delivery Challenges

- maintaining, increasing quality and level of service within budget constraints
- coping with heavy demands for service and growing wait lists

- service provision to clients living alone
- referrals when consumers in crisis
- providing service to clients whose first language is not English
- maintaining and promoting consumer autonomy
- transportation which is regional, accessible, affordable
- meeting needs for more flexibility in service hours
- shrinking pool of volunteers
- inadequate information technology for some organizations and lack of coordination of systems across agencies
- missing services (e.g., day hospitals, basic homemaking services)
- developing staff and volunteer capacity (i.e., skills, knowledge and willingness) to meet increasingly complex service needs
- turnover of experienced staff
- staff shortages, including personal support workers, therapists, nurses, physicians (including those with geriatric and paediatric expertise)
- effective communication and collaboration with other service providers
- fitting volunteers into the care plan
- dealing with the increasing number of single points of access to services (e.g., CCAC, Contact Niagara, Healthy Babies/Healthy Children, Speech Services Niagara)
- narrow service criteria and rigid interpretation of criteria resulting from budget constraints

3 **IMPACT OF INSTITUTIONAL SECTOR ON LONG-TERM CARE COMMUNITY SERVICES**

The purpose of this section is to summarize trends and issues affecting hospitals and long-term care facilities and how these impact the delivery of long-term care community services.

Highlights

- there are currently three hospitals in Niagara operating on ten different sites
- since 1989 there has been a 41% decrease in Niagara's acute care bed capacity and a significant reduction in the average length of stay
- Niagara is experiencing a very high level of alternate level of care days compared to the rest of the Central South planning region and most other parts of the province
- the Health Services Restructuring Commission (HSRC) requires hospitals to achieve clinical efficiencies through increased day surgery, reductions in length of stay, elimination of all alternate level of care patient days and avoiding/reducing unnecessary hospital admissions
- past and future changes in hospital activity place significant demands on all long-term care community based services
- since June 1996, Niagara has received close to \$30 million in new funding for community long term care services
- in 1998, the provincial government announced it will increase funding for community-based long-term care services in Niagara by an additional \$27.3 million by 2006; of this approximately \$5 million remains to be allocated
- in 1999, the HSRC estimated Niagara would require a \$6 million investment in post hospitalization in-home care and a further 1,387 additional community-based long-term care "places" in supportive housing, attendant care, in-home professional services and adult day care by 2003; however it is unclear to what extent these directions have been addressed in Niagara with the new funding announcements
- currently there are 2,868 beds in operation in 27 long-term care facilities in Niagara (plus 47 temporary beds), with an additional 646 beds approved by the MOHLTC to be in place by no later than 2004 (544 by March 2002 and 102 by 2004)
- several municipalities in Niagara have no long-term care beds and many have significantly fewer beds per 1000 aged 75 and over than the provincial average
- on any given day, there are over 1700 people waiting for placement in long-term care facilities in Niagara
- 9 of the 30 rest and retirement homes in Niagara have met the membership standards of the Ontario Residential Care Association (ORCA); these 9 homes have a total of 765 beds

3.1 **Hospitals**

In the previous plan, it was noted that Niagara had 10 hospitals, including 4 large urban-community facilities, 4 small facilities, a chronic care facility and a rehabilitation centre. While all 10 sites still exist, 8 of the 10 sites were amalgamated in March 2000 to form the new Niagara Health System, in keeping with the Directions of the Health Services Restructuring Commission. The other two facilities have retained their own governing structures: Hotel Dieu Hospital in St. Catharines, which has recently changed its name to the Hotel Dieu Health Sciences Hospital, Niagara and West Lincoln Memorial Hospital in Grimsby, which maintains a management affiliation with the Hamilton Health Sciences Centre.

The Health Services Restructuring Commission (HSRC) final report (March 1999) recommended the following:

- Niagara will require a reinvestment of \$6 million for the in-home care of patients following inpatient and same day surgery procedures. The HSRC specifically earmarks this money for the provision of service to patients following inpatient hospitalization. In May 1999 and September 2000, a total of \$8,922,698 (excluding funding to serve private schools/home schooled children) in new annualized funding was allocated by the MOHLTC to CCAC Niagara.
- Based on the current funding system, the HSRC estimated about \$28.6 million in additional annual funding will be required by 2003 to support the operating costs for 555 additional long-term care beds and 1,387 additional long-term care places in supportive housing, long-term home care, attendant care and adult day care. To date, the MOHLTC has approved 646 new beds for Niagara, to be built by 2004 (operating costs unknown). Also, there has been \$2,176,627 in new funding for adult day care, attendant care and supportive housing. However, it is not known how this translates into new long term care places. It is noteworthy that none of the \$8,922,698 in new CCAC funding noted above is available for longer term home care, but rather is used to provide services in association with an acute episode of care.

Note: Long-term home care was considered in general terms by the HSRC to include care of more than 180 days in a calendar year (either in a single episode or multiple episodes) – see HSRC Planning Guidelines, April 1998)

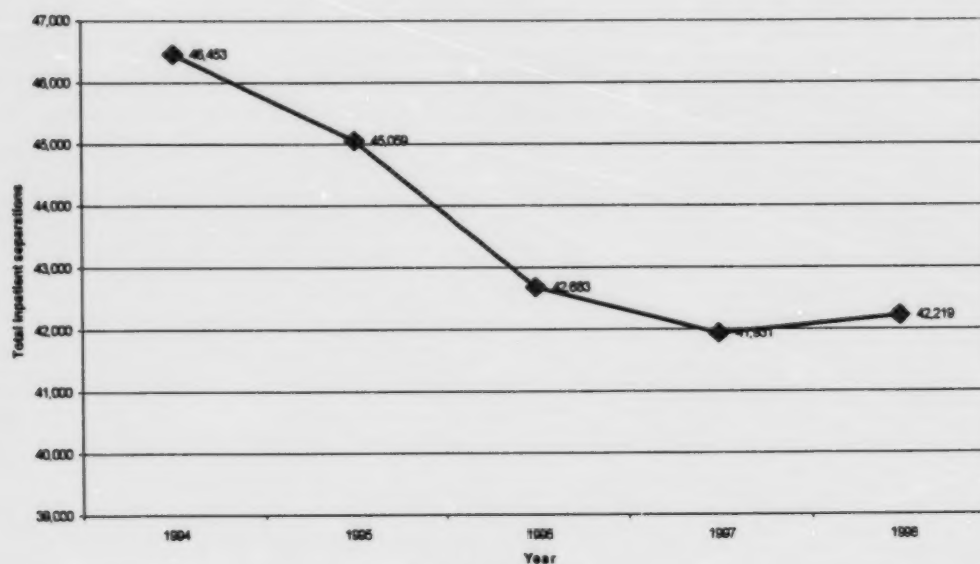
Implementation of the changes in the health system as described in the HSRC report for Niagara, involves substantial changes in the hospital sector. It will be important to ensure that the timing of these changes is well planned and coordinated with the proposed reinvestment in the long-term care sector.

Reduction in Hospital Discharges and Inpatient days

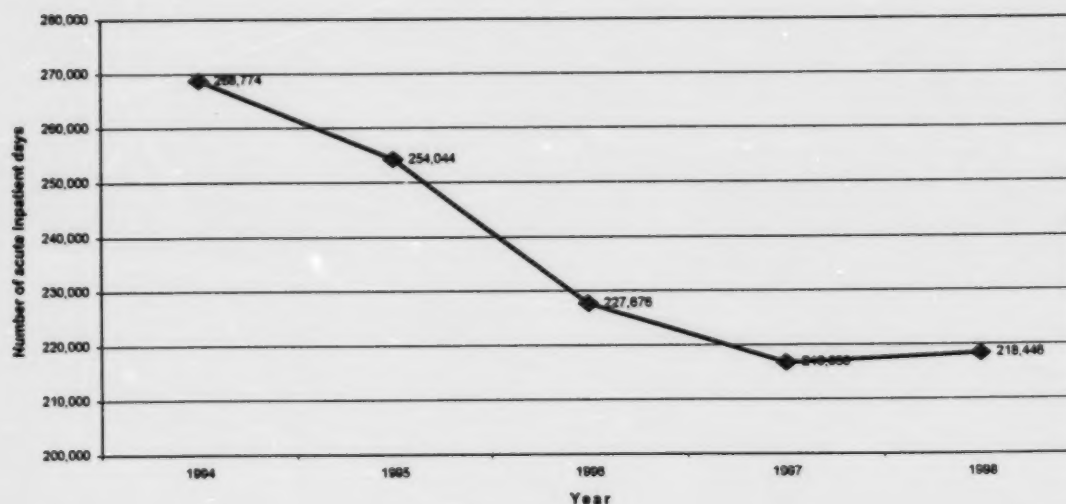
Discharges from hospital and days spent in hospital have decreased dramatically over the past several years, as illustrated in Figures 3.1a and 3.1b.

FIGURE 3.1a

Change in acute inpatient separations, Niagara hospitals, 1994/95 - 1998/99.

**FIGURE 3.1b**

Change in acute inpatient days, all Niagara hospitals, 1994/95 - 1998/99.



The following table compares actual bed numbers in 1995-96, 1997-98 and 2000-2001 in Niagara to those the Commission indicates will be required for 2003.

Changes in Inpatient Hospital Bed Numbers

Category of Care	1995-96	1997-98	2000-2001	Directions for 2003****
Acute*	884	763	728	576
Projected Growth**	--	--		96
Adult Acute Mental Health	71	71	61	79
Child & Adolescent Mental Health***	--	--	--	8
Long-Term Mental Health	0	0	0	53
Complex Continuing Care	416	339	343	288
Local Rehabilitation	22	22	22	85
Regional Rehabilitation***	--	--	--	17***
Transition-to-Independent Living	--	--	--	5
Sub-Acute Care	--	--	--	82
TOTAL	1,393	1,201	1,154	1,264

Source: Niagara Region Health Services Restructuring Report, March 1999

* estimate based on clinical efficiencies [see following paragraph] applied only to urban hospitals, rural hospitals maintained at 1997-98 bed numbers

** estimate only for purposes of sizing physical plant (acute bed growth has only been applied to non-rural hospitals, rural efficiencies and growth will be applied in Phase 2 [of HSRC review related to Rural & Northern Benchmarks])

*** to be located in Hamilton (total does not include these beds)

**** Directions = from the HSRC to the Board of Governors of the applicable facilities.

The above reveals there has been a 41% decrease in Niagara's acute inpatient capacity between 1989 and 2000. The changes in bed numbers are also demonstrated graphically in Figure 3.1c. Given that the rate of utilization of hospital and health services increases with age (see Figure 3.1d) and that it is projected that Niagara's elderly population will experience significant growth over the next decade, hospital bed capacity in Niagara will need to be closely monitored.

FIGURE 3.1c
Change in number of beds in Niagara hospitals, 1989/90 - 2003.

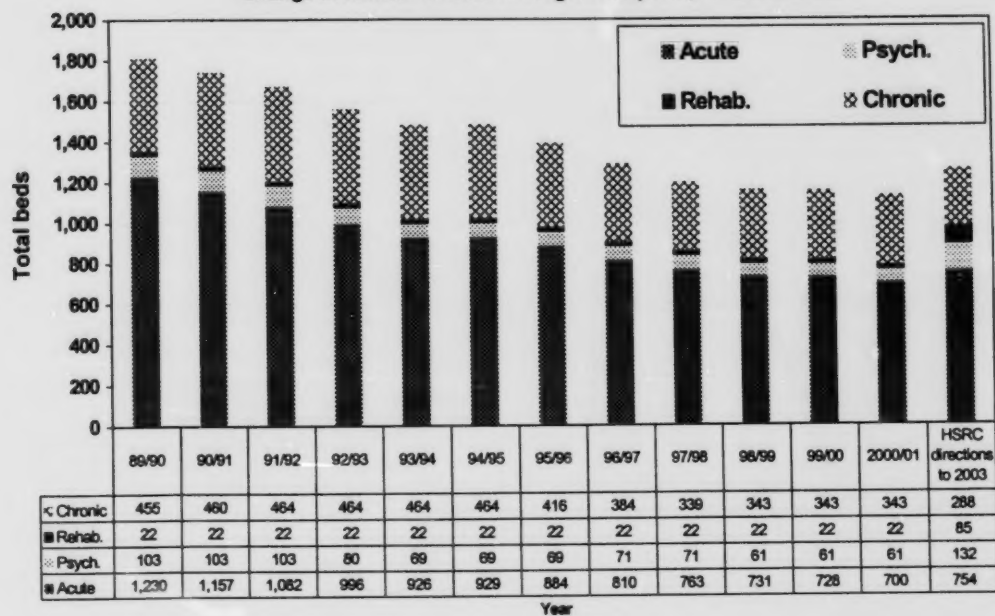
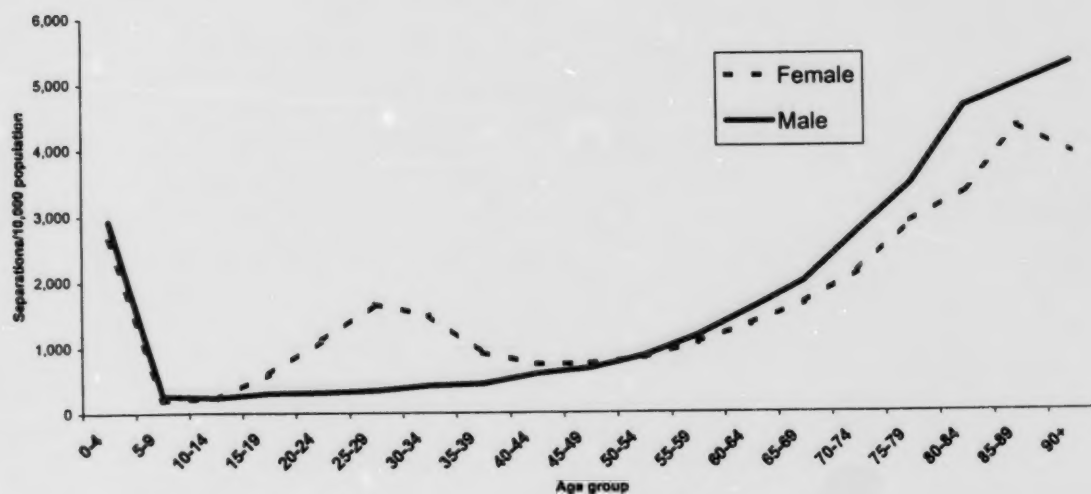


FIGURE 3.1d

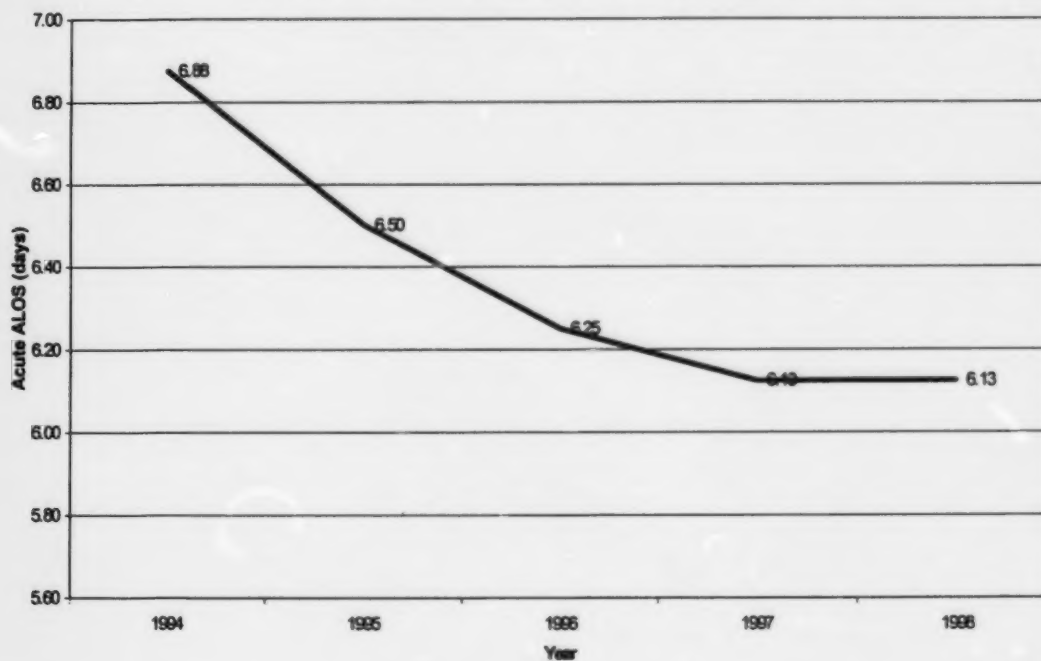
Acute Inpatient Hospital Separations per 10,000 population, Niagara residents, by 5-year age group, 1998.



Reduction in Average Length of Inpatient Stay

Average length of stay (ALOS) in hospital has an impact on the volume and type of clients referred to the long-term care sector by hospitals. Between 1994 and 1998, the average length of acute inpatient stay in Niagara's acute care hospitals decreased from 6.88 to 6.13 days.

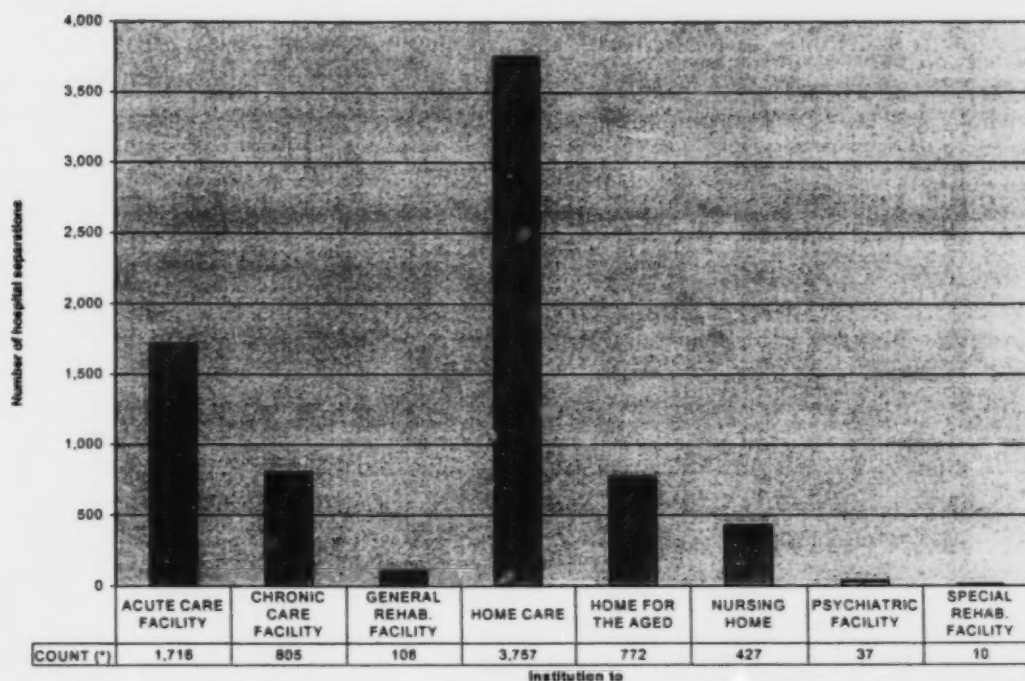
FIGURE 3.1e
Average Length of Acute Inpatient Stay,
Niagara's acute care hospitals, 1994/95 – 1998/99



Hospital Discharge Destinations

Figure 3.1f shows that for those receiving follow-up care after discharge from hospital, home care is by far the most frequent destination.

FIGURE 3.1f
Number of hospital separations by
Niagara residents by "institution to", 1998/99



Reduction/Elimination of Alternate Level of Care Patient Days

Alternate level of care (ALC) patient days are those where the patient occupies an acute care bed but is not considered to require acute care treatment. The patient may be waiting discharge home or for placement in a chronic care bed, a rehabilitation bed, or to a long-term care facility. The patient is ready for discharge from an acute care bed but the required alternative level of service is not immediately available. The patient must then occupy an acute bed when his or her needs could be better met in a less costly alternative setting. The determination of ALC status is a clinical decision which the attending physician must indicate on the patient's chart by issuing an "order" to change the level of care from acute and requests a transfer to another level of care.

The volume of ALC cases is an indicator of pressures on the long-term care system. A comparison of ALC days within Central South shows Niagara is about equivalent to the average for the planning region, and when comparisons are made across all planning regions in the province, Central South has the second highest number of ALC days, with only the North experiencing higher numbers (see Figures 3.1g and 3.1h). Figure 3.1i provides a breakdown of bed equivalents occupied by ALC

patients awaiting transfer by "Institution To" in 1998/99, there was the equivalent of 76 beds being occupied inappropriately by patients in Niagara's acute care facilities. The percentage of ALC days as a percentage of all acute days, by acute hospital site, is in Figure 3.1j. Anecdotally, it has been reported that some physicians are reluctant to issue the ACL order. Hence, these charts are considered to underestimate the ALC days in Niagara. At a meeting called by the Central South Region of the MOHLTC, involving the Niagara Regional Monitoring Committee, Public Health, CCAC, hospitals and ambulance services, to discuss the development of a proactive emergency services strategy for the upcoming flu season (see Section 3.3), the problem of ALC days in Niagara was raised. While it was agreed the solutions would be too complex to be included in the proposal given the limited funding and short timeframe for development of the proposal, the NHS agreed to take a lead role in facilitation discussions on this issue, together with other key stakeholders.

FIGURE 3.1g

ALC days as a % of total acute inpatient days, by district,
in Central South Region, 1998/99.

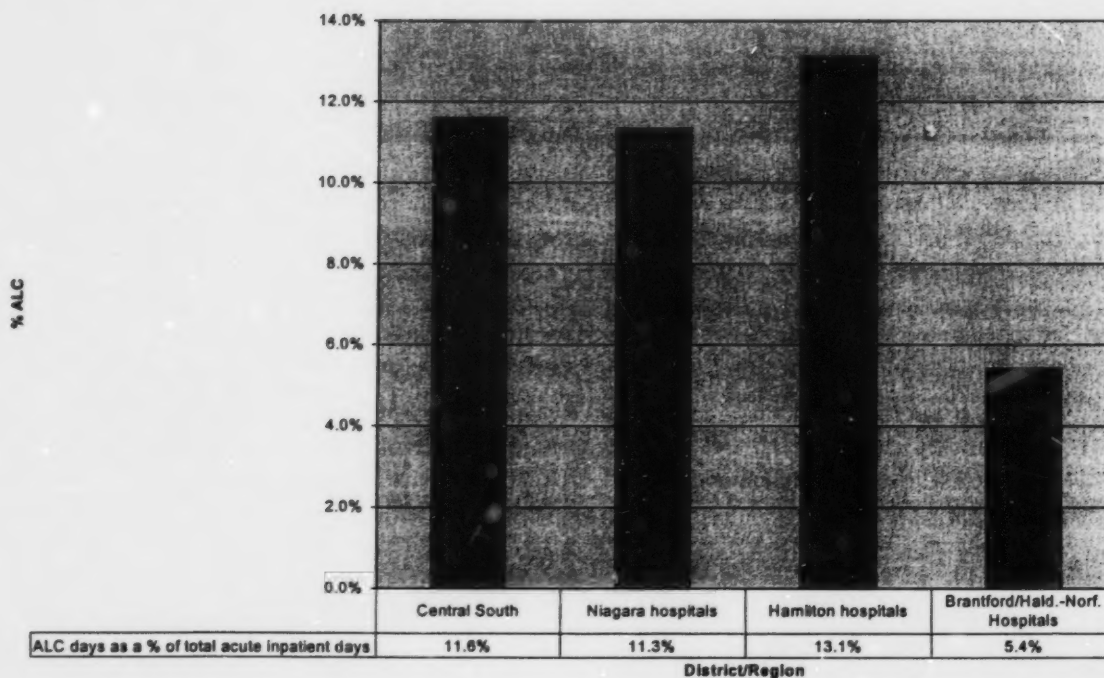


FIGURE 3.1b

ALC days as a % of total acute inpatient days, by planning region, 1998/99.

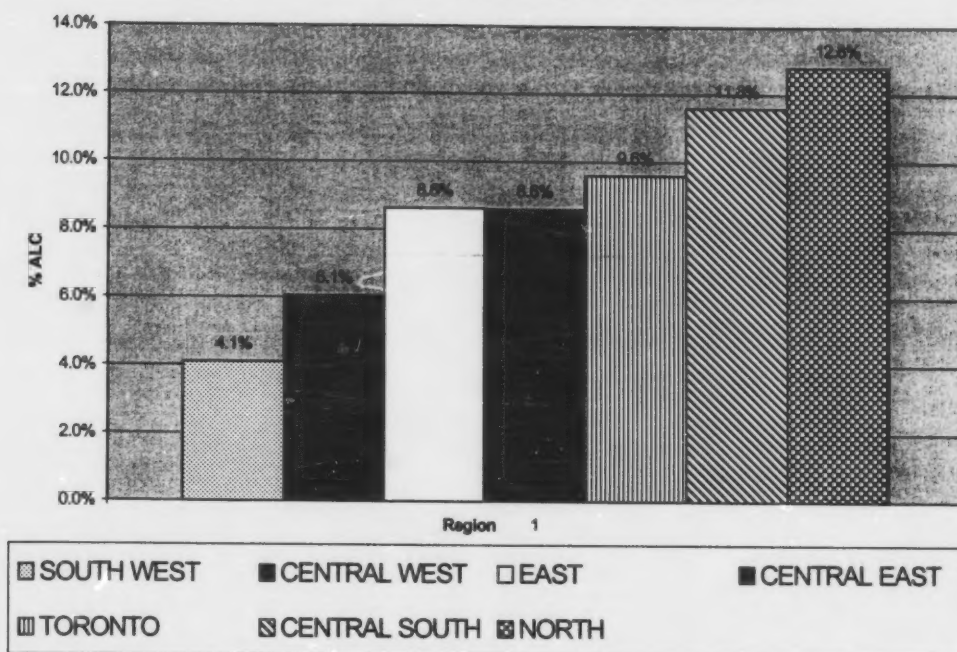


FIGURE 3.1i

Alternate Level of Care (ALC) acute hospital bed equivalents (ALC days/365),
Niagara hospitals, by institution transferred to, 1998.

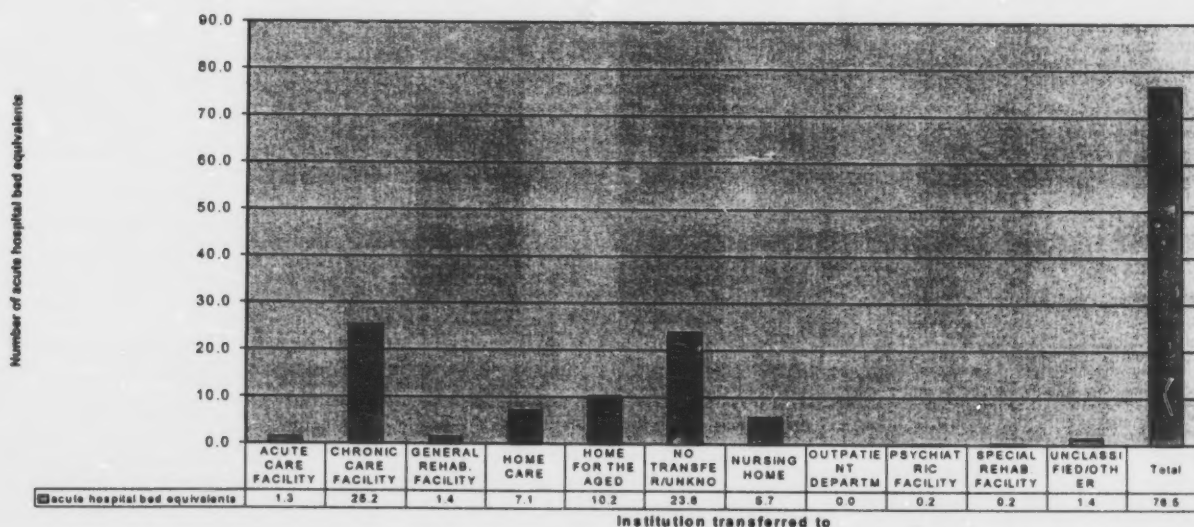




FIGURE 3.1h

ALC days as a % of total acute inpatient days, by planning region, 1998/99.

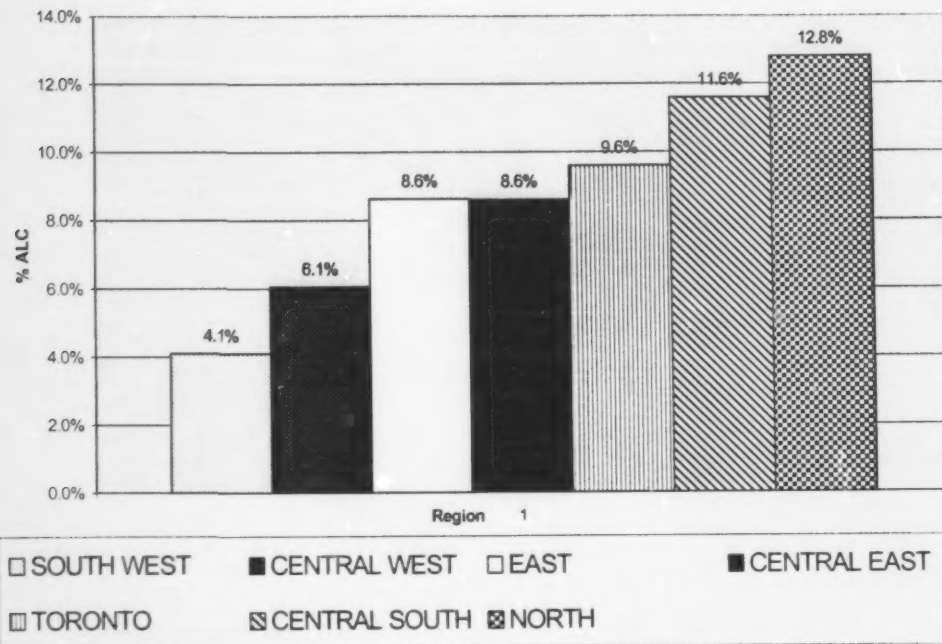


FIGURE 3.1i

Alternate Level of Care (ALC) acute hospital bed equivalents (ALC days/365),
Niagara hospitals, by institution transferred to, 1998.

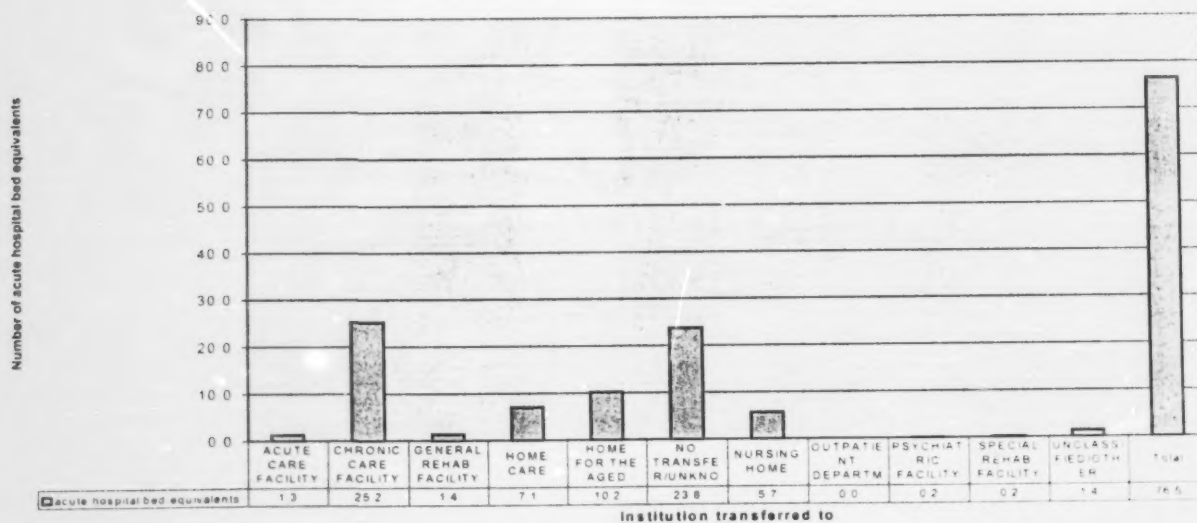
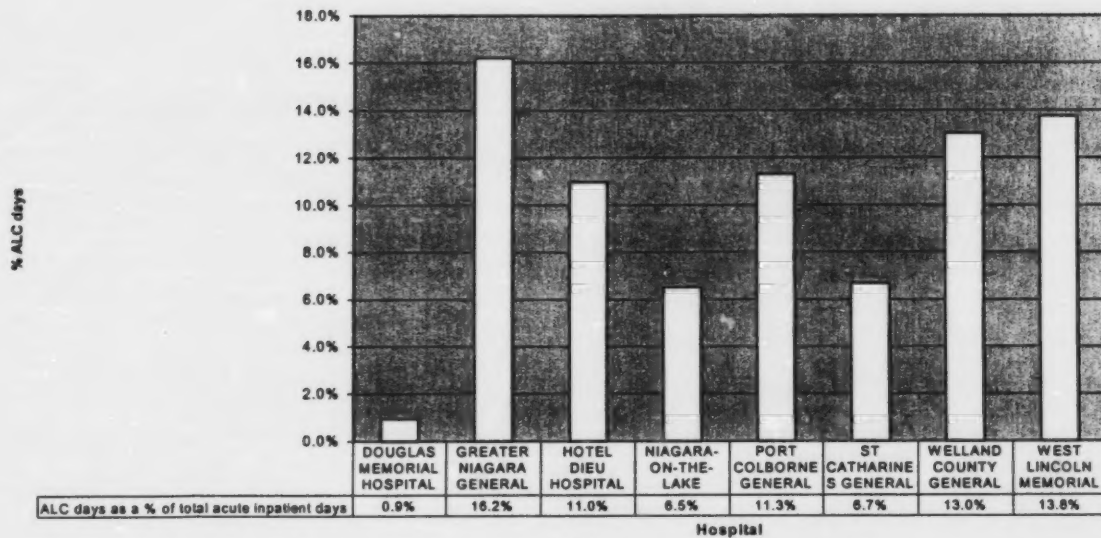


FIGURE 3.1j

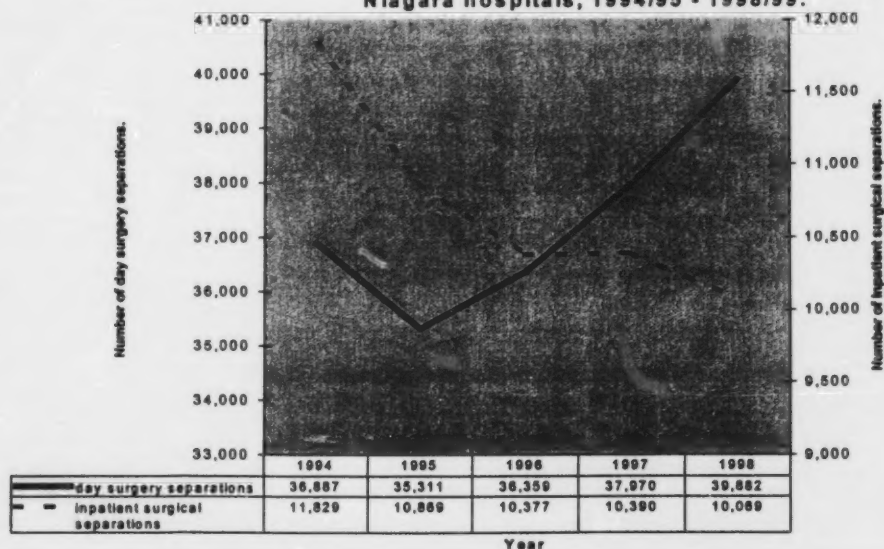
ALC days as a % of total acute inpatient days at Niagara hospitals, 1998/99.

**Conversion to Day Surgery**

There has been a significant shift from inpatient to day surgery across the province over the past few years. This applies equally to Niagara as illustrated in Figure 3.1k. Hospital representatives confirm the importance of in-home services being able to respond to the needs of patients returning home after day surgery.

FIGURE 3.1k

Trends in inpatient and day surgery separations in Niagara hospitals, 1994/95 - 1998/99.



Reduction in Outpatient Rehabilitation Services

Reductions in hospital outpatient physiotherapy services has impacted on the demand for therapy services by community service providers (e.g., CCAC, The Arthritis Society, Consultation and Rehabilitation Service and private clinics).

The foregoing section reinforces the importance of the Joint Executive Committee* and boards of Niagara's hospitals working together with the board of CCAC Niagara to establish the links and protocols needed to ensure essential in-home supports are in place prior to hospital discharge. While even before the formation of the JEC there has certainly been progress in developing such links (e.g., joint development of clinical pathways) and improving communication amongst the hospitals/sites and the CCAC, these efforts require strengthening and continued attention. See section 3.3 for a discussion of a concrete example of hospitals working cooperatively with the CCAC as well as the long term care facility sector.

While the CCAC is the largest long term care community service provider, hospitals also need to be aware of and work closely with other community service providers. This relationship is required at the administrative level as planning takes place for program changes which could impact on the community sector. It is also required at the patient care/discharge planning level, to ensure all required community supports are in place prior to discharge.

3.2 Residential Settings

3.2.1 Long-term care facilities

As of February 2001, Niagara is operating a total of 2,868 permanent long-term care beds in 27 long-term care facilities. As well, there are 47 interim beds in operation, all of which are located in Nursing Homes in St. Catharines and Niagara-on-the-Lake. These beds are intended to be temporary pending the addition of 646 new beds approved for Niagara to be built by 2004. Of these, 574 were awarded through 2 separate RFP processes in 1998 and 1999. The process for awarding the balance of beds is currently in progress. Note: a facility which was awarded 30 beds in the first RFP in 1998 will not be building; hence the balance of 72 beds yet to be awarded has been adjusted upwards to 102 beds and those actually awarded downwards to 544.

One facility in Lincoln, the Nipponia Home for the Aged closed its 23-bed facility early in 2000. A letter was sent by the Niagara District Health Council to the Regional Director, Central South Region of the MOHLTC in July 2000, asking that these 23 beds be reallocated

* The formation of the Joint Executive Committee between the Niagara Health System and Hotel Dieu Health Science Hospital, St. Catharines, was mandated by the HSRC to implement the HSRC directions.

in Niagara. The response received in September 2000 acknowledged that the new beds promised in Niagara do not reflect the closure of Nipponia, but no decision regarding reallocation of the 23 beds could be made until legal matters relating to the closure have been settled.

See Appendix C for a breakdown of the facilities/beds in Niagara now and upon building the new permanent beds.

In Niagara, the current operating ratio is 90.9 beds/1,000 population 75 and over, based on 2,915 beds, which includes the temporary beds; this will increase to 106.4 with the new beds awarded and to 110.3 if one takes into account all of the new beds (i.e., including the 102 additional beds not yet awarded and reallocation of the 23 beds closed in Lincoln).

The existing and planned ratios of LTC beds/1000 population in each municipality in Niagara are included in Appendix D. This reveals that several municipalities in Niagara have and will continue to have no long-term care facilities within their boundaries and/or significantly fewer beds than the provincial average number per 1000 people aged 75 and over. The planned redevelopment of the Regional Homes for the Aged will not change the overall numbers of beds, but will change the distribution; this will result in higher ratios in St. Catharines, Niagara Falls and Port Colborne, and a lower ratio in Welland.

The mix of facility sizes in Niagara ranges from as few as 36 beds to as many as 231. Several smaller facilities continue to experience ongoing financial difficulties which jeopardize their continued viability.

Waits for admission

There continues to be a lengthy waiting list of people who can no longer function in their own homes or in a retirement home without continuous nursing and personal care and who require admission to a long-term care facility. Table 3.2.1 provides a snap-shot of the waiting list at a point in time over the past four years. The latest figures available are as of November 30, 2000.

TABLE 3.2.1
Current Waiting List for Admission to a Long-Term Care Facility in Niagara

Current Location	1996		1998		2000	
	Number	% of Total	Number	% of Total	Number	% of Total
Community	495	48.6	606	53.3	973	55.9
Another long-term care facility*	273	26.8	291	25.6	402	23.1
Hospital (acute & chronic)	117	11.5	92	8.1	171	9.8
Other (psychiatric and rehab hospitals)	15	1.5	29	2.5	27	1.6
Outside Niagara**	118	11.6	120	10.5	168	9.6
TOTAL	1,018	100.0	1,138	100.0	1741	100.0

Source: Community Care Access Centre Niagara, Placement Coordination Service Statistics.

* People currently in another long-term care facility are waiting for admission to their first choice of facility

** Of the 120 people outside Niagara waiting for admission to a long-term care facility in Niagara, 84 were living in the community, 24 were in another long-term care facility, 8 were in a chronic care bed and 8 were in an acute care bed

Facilities need appropriate funding to acquire the professional expertise and equipment needed to ensure an acceptable quality of life for existing residents. Significantly more funding per bed will be needed to cope with the further dramatic changes which will be occurring as a result of refocussing the role of chronic hospitals and units on complex continuing care. Increased professional staffing hours will be needed to care for residents with high intensity needs.

Individuals with psycho-geriatric problems and specialized care needs

In March 1999, the provincial government released a discussion paper on Ontario's proposed strategy for Alzheimer Disease and related dementias. Strategies outlined in the paper will help address the significant needs of those living with the effects of Alzheimer disease and related dementias. The strategies include:

- improved annual training for front-line long-term care staff and CCAC case managers
- funding all Ontario chapters of the Alzheimer Society to hire public education coordinators
- development of a standardized physician training program
- increased funding to expand Alzheimer adult day care spaces and Alzheimer extended (volunteer) respite services.

In September 2000, the Region of Niagara received \$167,231 for enhancement of its adult day services. This funding will be used to extend hours of existing programs and to develop specialized activity programs for participants with dementia and higher needs.

Funding (approximately \$160,000) has also been made available for two Psychogeriatric Consulting Resource persons in Niagara as part of the Alzheimer Strategy. Identification of a sponsoring organization is in the process of being determined. These individuals will provide support and education to long term care facility staff and community agencies and assist in developing networks and contributing to the integration of mental health and long-term care services.

A new Alzheimer Resource Centre is being built in St. Catharines on the grounds of Linhaven, a municipal Home for the Aged. A planning group has also been formed to develop a specialized, regional dementia care centre at Linhaven as part of the redevelopment of three of the Region's seven Homes for the Aged. Discussion is currently focussed on a 22 bed centre, including 16 beds for short term complex care and 6 beds for short-stay respite. This centre would serve residents in long term care facilities with very complex needs.

In September 2000 Niagara District Health Council, on the advice of the Long Term Care Committee, wrote a letter to the Regional Municipality of Niagara in support of recommendations arising from the Homes for the Aged Medical Directors Annual Reports for 1999. The recommendations relate largely to dementia care, including:

- increasing "hands-on" nursing (particularly for dementia care);
- increasing activation of residents (particularly through rehabilitation);
- increasing staff training (particularly in dementia care and specialized care such as intravenous therapy); and
- continued efforts to improve dementia care (particularly through on-unit activities, improved staffing, volunteer and family involvement, one-on-one intervention and short-term assessment and intervention in the proposed new dementia care centre (as noted above) with follow up at local long term care facilities).

As well, as described in Section 7, the Niagara Specialized Health Care for the Elderly Network Group has been formed to oversee implementation of the Reports of the Specialized Health Services for the Elderly Task Force of the DHC.

Recommendation

- 3.2.1.1 THAT the MOHLTC allocate adequate funding for LTC facilities to care for higher intensity needs residents and for specialized dementia care

3.2.2 Rest and Retirement Homes

Thirty rest and retirement homes in Niagara offer residential care and support on a fee-for-service basis. The homes are subject to municipal zoning, public health and fire codes, however, care and services provided in the homes are not regulated by the provincial MOHLTC.

With the scarcity of long-term care beds and long waiting lists, some rest and retirement homes in Niagara are now caring for residents with higher levels of needs. Some are finding residents' care needs are beyond what their staffing can support and are turning to the CCAC for assistance. Some homes may not be aware of other community support services they may be eligible to access for their residents.

The increasing complexity of care requirements of residents in rest and retirement homes clearly points to the need for assurance that quality standards are being maintained, through some form of regulatory or review process, similar to the long term care facilities.

According to the OCRA website, January 2001, 9 rest and retirement homes in Niagara with a total of 765 beds are members of the Ontario Residential Care Association. Membership in ORCA is contingent upon successfully meeting and maintaining comprehensive standards established by the Standards Evaluation Program of the association.

In January 2001, a new provincially funded Complaint and Information Service was announced by the OCRA, which will encompass both ORCA members and non-members.

Recommendation

3.2.2.1 THAT the MOHLTC pursue development of a regulatory process for rest and retirement homes that will provide an objective assessment of the quality of care and services provided

3.3 The Community/Facility Interface

As noted briefly in Section 3.1, Niagara was asked to develop a Proactive Emergency Services Strategy as part of a provincial investment of more than \$100 million to address potential pressures on emergency departments during the winter flu season (i.e., when situations of ambulances having to be diverted due to overwhelmed emergency departments tends to escalate). In Niagara, \$290,000 annualized funding (\$145,000 in fiscal 2000/2001), was made available for an Emergency Department System Coordinator and timely discharge planning initiatives.

In the DHC Report of the Ambulance By-pass Task Forces, October 1998, it was noted that the causes and implications of emergency departments having to go on ambulance by-pass are multi-faceted and include factors related to the appropriateness of Emergency Department utilization, the

availability of critical care and other inpatient beds, and the availability of long term care beds and community resources--in other words, it is a system problem and not just a hospital/emergency problem. Given this background, the development of the proposal for Niagara was a cooperative effort, involving hospitals, ambulance services, the CCAC and representatives of long term care facilities and rest and retirement homes.

The key components of the proposal include:

- an ER System Coordinator to ensure efficient movement of patients across the continuum of hospital services from admission to timely discharge in order to minimize ambulance by-pass situations;
- Advance Practice Nurses to provide clinical consultation to LTC facilities in order to reduce transfers to emergency/hospital admissions and expedite discharges to LTC facilities;
- Long-Term Care facility staff-up funds to support facilities in extending their hours for new admissions and to care for higher intensity needs residents (e.g., IVs);
- an Education Coordinator to educate LTC facility staff to provide extended treatments to residents and to educate the public and physicians/offices on the appropriate use of the Emergency Department; and
- "On-call" hours for CCAC placement co-ordinators to enable initiation of bed offer placement services for LTC beds that come available on weekends/statutory holidays.

A number of other initiatives to be introduced but not funded through this initiative and suggested policy changes are highlighted in the proposal summary included in Appendix E - A survey of Long Term Care facilities and Rest and Retirement Homes was conducted following submission of the proposal to inform implementation, (e.g., to determine any excess bed capacity, admission hours, ability to care for higher intensity residents).

Challenges facing the CCAC highlighted in the previous plan have continued and escalated. There is a great deal of concern in Niagara that services have moved to the community without sufficient funding to support this shift. There is a strong need for resources to support implementation of additional long term care places as identified by the HSRC.

4 *INVENTORY OF CURRENT LONG-TERM CARE COMMUNITY SERVICES*

A detailed inventory of community long term care services funded by the MOHLTC is maintained by the Niagara District Health Council. This inventory, including units of service, clients and unit costs, is updated as agency service plans become available from the MOHLTC. However, for a variety of reasons (including the fact that not all recent funding expansions have been fully implemented), not all agency plans with the required data have been received; hence, presentation of a comprehensive, meaningful inventory is not possible at this time but will be provided in future plans.

An inventory of agencies providing community long-term care services in Niagara is included in Appendix F.

5 REVIEW OF DISTRICT SERVICE PLANS FROM PREVIOUS YEARS

The purpose of this section is to review the current status of recommendations identified in the previous annual district service plan.

Significant progress has been made in improving access and availability of services in Niagara since Niagara's first annual district service plan for long-term care community services was endorsed by Council in June 1996 and since development of the most recent plan approximately one and a half years ago. For example:

- new funding has been approved to support enhanced and expanded operations
- service providers, consumers and policy makers meet more regularly to discuss issues and plan for improved information sharing and collaboration
- information technology needs have begun to be addressed to support the development of an efficient, effective system of service delivery.

However, much more needs to be done before community services in Niagara funded by the MOHLTC will be able to meet the steadily growing need for service.

5.1 Funding Related Recommendations

Since development of the 1999/2000 ADSP, the MOHLTC has allocated a total of \$13,119,499 in additional, annualized funding for community long term care services in Niagara (including Alzheimer Strategy funding). The first announcement was made in April 1999 for a total of \$6,031,229; of this, 4,144,711 was allocated to the CCAC and 1,886,518 was allocated to other community long term care services, representing a 69/31 split on a percentage basis. Four announcements totalling \$6,989,975 were made in September 2000, one for \$6,491,968 for CCAC and other community long term care services, another for \$121,173 for the CCAC to serve private schools and home-schooled children; another for \$209,603 for the Children's Treatment Centre and yet another for \$167,231 for Adult Day Services as part of the Alzheimer Strategy. In February 2001, additional funding of \$98,295 was announced for the CCAC to serve private schools and home-schooled children, bringing the total new funding announced in 2000-2001 to \$7,088,270. These allocations were Niagara's share of the \$1.2 billion plan for long-term care announced in April 1998, of which \$551 million was earmarked for community long term care services.

The first announcement in September 2000 included \$1,251,096 in stabilization funding, which means each funded agency received an increase of 2% on their base budget as of March 31, 2000 (\$847,333 for CCAC and \$403,763 for all other community long-term care services including Children's Treatment Centres). The CCAC received an additional \$3,930,654 on top of their 2% increase (total \$4,777,987). They were subsequently informed that an additional \$219,468 would

be allocated to serve private school and home-schooled children bringing the total announced for the CCAC in 2000-2001 to \$4,997,445. In addition, 11 non-CCAC programs received increases totalling \$1,310,218 (total 1,713,981 including stabilization). This represents a 75%/25% split in the allocation between CCAC and non-CCAC programs, after the stabilization funding. Following this announcement, the Children's Treatment Centre received \$209,603 in new annual funding on top of their stabilization funding of \$36,438 (total \$246,041).

Another announcement in September 2000 was for \$167,231 to expand respite (adult day) services as part of the Alzheimer Strategy; as well, an announcement is anticipated shortly to fund two psychogeriatric consultant positions, also as part of the Alzheimer Strategy.

The chart below provides a summary comparison of the allocations for the various service categories in comparison with the recommendations in the 1999/2000 ADSP. A reference to the applicable recommendation and the page number is provided in brackets.

Service Category	Recommended in 1999/2000 ADSP	May 1999 and September 2000 MOHLTC Funding Announcements combined compared to recommendation	Balance
Caregiver support: support & counselling Services (rec. 6.1.1, p.26)	\$ 800,000	\$ 62,500	(\$ 737,500)
Caregiver support: extended respite services (rec. 6.2.1, p.28)	\$ 300,000	Nil	(\$ 300,000)
Caregiver support: training, education & information (rec. 6.3.1, p.29)	\$ 275,000	\$ 12,500	(\$262,500)
Community support services: ➤ MOW ➤ Transportation ➤ Friendly Visiting ➤ Security Checks ➤ Home Maintenance and Repair (rec. 6.4.1, p.31)	\$ 1,350,000 total	\$ 439,514	(\$ 910,486)
Adult day services : seniors/dementia (rec. 6.5.1, p.32)	\$ 1,000,000	\$ 306,677 167,231 (Alz.Strat) \$ 473,908	(\$ 526,092)
Adult day services: ABI (rec. 6.6.1, p.33)	\$ 300,000	Nil	(\$ 300,000)
Life Skills: ABI Outreach (rec. 6.7.1, p.34)	\$ 500,000	\$ 398,830 + **	(\$ 101,170)

Service Category	Recommended in 1999/2000 ADSP	May 1999 and September 2000 MOHLTC Funding Announcements combined compared to recommendation	Balance
Homemaking/personal support/ attendant/respite: adults with disabilities (rec. 6.10.1, p.37)	\$ 600,000	\$ 810,194	+ \$ 210,194
CCAC services (post-hospitalization, visiting professional and homemaking) Private schools/home schooled (rec. 6.13.1, p.41) (incl. Stabilization)	\$ 6,000,000	\$ 8,922,698 <u>\$ 219,468</u> <u>\$9,142,166</u>	+ \$ 3,142,166
Palliative care services: Pain and symptom management Volunteer Hospice Visiting (rec. 6.14.1, p.43)	~\$ 110,000 ~\$ 140,000 \$ 250,000 total	Nil <u>\$ 56,765</u> \$ 56,765	(\$193,235)
Special services for the blind and visually impaired (rec. 6.16.1, p.45)	\$ 62,000	\$ 50,000	(\$12,000)
Supportive living/housing services (rec. 6.18.1, p.48)	\$ 2,500,000 (elderly, physically disabled, ABI combined)	\$ 1,059,756**	(\$1,440,244)
Children's Treatment Centre services (6.19.1, p.49) (incl. Stabilization)	appropriate funding to meet escalating needs	\$ 246,041	+ \$ 246,041
Stabilization Funding (non-CCAC and non CTC)		\$ 367,325	\$ 367,325
Total	\$13,937,000*	\$13,119,499	(\$ 817,501) ***

* PLUS: Additional funding to support the operating costs for an additional 1,387 long-term care places arising from the restructuring of hospital services in Niagara and recommended by the Health Services Restructuring Commission for supportive housing, homemaking/personal support/attendant/respite services, adult day services and visiting professional services.

** the breakdown of funding was \$527,562 for elderly, \$337,194 for ABI and \$195,000 for HIV/AIDS; a small portion of the ABI Supportive Housing funding is for Life Skills - ABI Outreach

*** While the overall balance outstanding amounts to \$ 817,501 there is still \$4,783,227 in outstanding recommendations.

The announcements for ongoing funding bring the total additional funding for Niagara from the community envelope and the Alzheimer Strategy since June 1996 to \$29,981,204. There still remains \$4,810,501 to be allocated out of the \$27,300,000 announced for Niagara by the MOHLTC approximately 2 1/2 years ago.

5.2 Other recommendations

The following summarizes the status of non-funding recommendations made in the 1999-2000 ADSP.

RECOMMENDATION	STATUS - SEPTEMBER 2000
THAT the MOHLTC support the collaborative efforts of the seven member agencies of Community Support Services Niagara to develop, manage and provide consistent community support services in all areas of Niagara for elderly people and others requiring such services (rec. 6.4.2, p.31)	The Fort Erie, Niagara Falls/NOTL, St. Catharines/Thorold and Port Colborne Meals on Wheels organizations made a decision to withdraw from CSSN. West Niagara Community Support Services and Meals on Wheels/Community Support Services (Welland/Pelham) amalgamated as of late 2000 (i.e., following funding announcement of September 2000 of \$200,000 in additional annualized funding). They will offer a complete package of community support services to other parts of the region not providing them, i.e., home maintenance and repair, security checks, friendly visiting. The Canadian Red Cross is the main provider of volunteer transportation in the Region. The Region of Niagara is discussing with the MOHLTC the potential to discontinue provision of their existing community support services and provide Client Intervention and Assistance services to the Region.
THAT the MOHLTC work with the Ontario March of Dimes to identify the potential of the newly defined 'Life Skills Outreach-Physically Disabled Adults; service (09G) to meet the needs of persons now receiving service through its collaborative program with Brain Injury Community Re-entry Niagara (rec. 6.6.2, p.33).	Discussions in progress.
THAT the MOHLTC alert the Friendship Centres in Niagara to the availability of funding for the newly defined 'Aboriginal Support Service' (09X) and work with them to determine the level of need locally (rec. 6.8.1, p.35).	Both Friendship Centres in Niagara were made aware of the service. Ministry and DHC staff met with the Fort Erie Friendship Centre. The Centre already provides this type of service through funding it receives through the Ontario Federation of Native Friendship Centres. Centre expressed interest in pursuing training of aboriginal Personal Support Workers.
THAT the MOHLTC work with the Niagara Gatekeepers Program to identify the level of need for 'Client Intervention and Assistance Services (Seniors)' (09I) in communities throughout Niagara (rec. 6.9.1, p.36).	Both Ministry and DHC staff worked with Gatekeepers Task Force. Proposal submitted to Ministry for "Integrated Approach to Serving Vulnerable Adults in the Niagara Region" submitted by Gatekeepers, CCAC Niagara, Community Services Department. There is currently no mechanism for the Ministry to fund the "Outreach/Education" component of the model. The CIA definition is currently under review by the Ministry. Potential for funding Gatekeepers in the next year's funding allocation.

RECOMMENDATION	STATUS - SEPTEMBER 2000
THAT the MOHLTC publicize the availability of "Self-Managed Attendant Service – Direct Funding" (12H) and identify organizations in communities across Ontario to respond to questions from interested people and to support individuals in accessing the service (rec. 6.12.1, p.39).	This is taking place through Centres for Independent Living, in Niagara through the Niagara Centre for Independent Living. Ontario March of Dimes is also promoting this option through its Outreach Program.
THAT the MOHLTC identify a policy framework to support the funding and operation of residential hospices to meet the growing need for alternative approaches to caring for persons living with a terminal illness who do not need treatment in a hospital setting (e.g., proposal from Hospice Niagara in partnership with the Salvation Army) (rec. 6.14.2, p.43).	No policy framework to date. Hospice Niagara received Trillium Grant funding to pursue funding and support for a 10-bed residential hospice.
THAT the MOHLTC identify a policy framework to support the funding and operation of residential services to meet the needs of persons with acquired brain injuries who are minimally responsive to external stimuli (e.g., proposal from Headway Homes) (rec. 6.18.2, p.48).	No policy framework to date, discussions continue.
THAT the Province of Ontario provide capital funding and government policy support to build and/or renovate accessible, subsidized housing units for people with physical disabilities (rec. 6.18.3, p.48).	None to date.
THAT the MOHLTC continue to support AIDS Niagara in working with other agencies in Niagara to help staff meet the particular needs of residents receiving supportive housing services (rec. 6.18.4, p. 48).	MOHLTC provided an additional \$195,000 in annualized funding for expansion of AIDS Niagara's Supportive Housing Program (in September 2000 announcement).
THAT the MOHLTC complete the provincial review of Children's Treatment Centres and allocate appropriate funding to meet the escalating needs for service (rec. 6.19.1, p.49).	Review completed and \$4 million allocated across the province. Niagara's share \$209,603 (plus 2% stabilization = \$246,041).

* See separate table in Section 5.1 for funding-related recommendations

6 NEED FOR IMPROVED/CHANGED SERVICES

This section provides a summary of the current situation with respect to funded long-term care community services in Niagara and specific recommendations for service improvement.

Niagara's 1997-98 Annual District Service Plan estimated the level of funding required to bring service levels in Niagara up to comparable levels available per capita in the rest of the province. Estimates were based on the best information available at that time, including:

- Ministry information about the levels of similar services available per capita in other parts of Ontario in 1995-96
- population projections for Niagara based on 1991 census data
- 1995-96 unit costs for service
- 1994-95 hospital activity levels (average lengths of stay, bed numbers, outpatient/same-day surgery levels, etc.).

Since 1997-98, new information is available on the size of Niagara's population and projections about its growth into the next century based on the 1996 census and on hospital activity levels for 1998-99. There has been no new data released comparing Niagara's community service levels to other parts of the province. Projected service levels are available based on Agency Service Plans up to 2000-2001, although this data is incomplete and actual service levels are unknown in most instances.

The MOHLTC annually updates its definitions of community services eligible for funding through its Health Programs Division. Definitions of eligible services are published in the Ministry's "Planning, Funding and Accountability for Long-Term Care Community Services: Policies and Procedures Manual". Council's Long-Term Care Committee used the January 2000 definitions of eligible services in its review of services, although the status of some service categories in the December 2000 version received just prior to completion of the plan, was referenced in preparing its final recommendations..

6.1 Caregiver Support Services: Support & Counselling (08A)

Overview of current situation

Three organizations in Niagara are funded by the MOHLTC to provide therapeutic caregiver support and counselling services:

- Alzheimer Society of Niagara for caregivers of persons with dementia
- VON Niagara for caregivers of persons with Parkinson's Disease
- AIDS Niagara for caregivers of persons living with HIV/AIDS.

Many other organizations provide peer support and counselling without specific funding support from the MOHLTC. Examples of these organizations include: the Multiple Sclerosis Society of Canada, Niagara Peninsula Chapter of Hope (St. Catharines, Thorold, Grimsby, Niagara Falls), the Head Injury Associations of Niagara and of Fort Erie, and Epilepsy Niagara.

Issues in 1999-2000 ADSP Update

- insufficient long-term care beds and lack of other resources (e.g., crisis in-patient beds, psychogeriatric assessments, etc.) extend burden and need for support/counselling of caregivers of persons with dementia
- growing population of persons with Parkinson's Disease and need for support for caregivers in late thirties and early forties
- increasingly caregivers are taking on challenges of caring for persons at home during end stages of illnesses (i.e., dementia, AIDS)
- insufficient resources for follow-up

Issues in 2000-2001

- waits for service exist
- caregiving role is extremely demanding and stressful and yet caregivers themselves are increasingly frail
- many families become caregivers due to lack of resources available to assist them and not by choice
- paid respite services in heavy demand

Status of funding recommendations made in previous plans

Total previous recommendations *:	\$ 800,000
Total allocated:	<u>62,500</u>
Balance*:	\$ 737,500

* based on importance of this service in helping caregivers cope with the ongoing burden of in-home care and the lack of resources existent in Niagara

Recommendations

- 6.1.1 THAT the MOHLTC allocate up to \$150,000 to provide additional caregiver support and counselling services (08A) for individuals caring for people living at home with chronic, degenerative conditions, and allocate the remainder of the outstanding balance to provide respite for families.

6.2 Caregiver Support Services: Respite (08C and 08G)

Overview of current situation

In 1998-99, the following organizations offered *in-home* respite services:

1. *Planned, short-term & long-term, day or night*

- Regional Municipality of Niagara, Community Services: for caregivers of persons with dementia
- Brain Injury Community Re-entry Niagara, Inc.: for caregivers of clients
- Ontario March of Dimes: for caregivers of clients
- Community Care Access Centre, Niagara: for caregivers of clients

2. *Unplanned, crisis/emergency short-term respite*

- Ontario March of Dimes: for caregivers of clients, through outreach services

Planned in-home respite services, except the respite service for persons with dementia provided by the Regional Municipality of Niagara, are provided as part of the homemaking/attendant care outreach/personal support services provided to eligible clients of the respective organizations.

According to government policy direction, effective April 1, 1999 there would be two levels of "respite service":

- the First Level is provided through Community Care Access Centres as part of the visiting homemaking/personal support and visiting nursing services. In-home short and long term respite service will be available through CCAC Niagara within government defined maximum limits (approximately 60 hours per month).
- the Second Level of extended respite service (08G) may be provided by community support service agencies. This "extended respite" service may be used to supplement services provided by the CCAC for persons who require extensive amounts of respite service on either a short or long-term basis or when someone is on the waiting list for CCAC service but not a priority for service. The MOHLTC will fund the administration costs associated with this service, but not direct service to be provided by volunteers, paid staff or through brokerage.

Further, the government policy stated that the paid respite service (08C) would not be expanded or funded as services but could continue to be funded at current levels until program and policy work is completed or until they are replaced by service reform. As of late 2000, the paid respite service offered by the Regional Municipality of Niagara, Community Services Department (known as the Respite Companion Program, for caregivers of clients with dementia) continues to operate and continues to be in heavy demand.

There has been a delay in implementing the extended respite service due to concerns about the use of volunteers to care for high needs families, who often require support on short notice and during

off-hours such as nights and weekends, and also due to the undesirability of families having to pay for the additional services.

Issues in 1999-2000 ADSP Update

- 180 caregivers of people with dementia waiting for access to planned in-home respite services from the Regional Municipality of Niagara
- significant need for respite for caregivers of the over 600 people in the community on the wait list assessed as eligible for admission to a long-term care facility
- providing service for persons whose first language is not English is a particular problem for clients with dementia whose "second" language skills are often lost early in the disease process
- increasing need for respite for caregivers of persons with acquired brain injuries facing burden of aging dependants and those with degenerative diseases

Issues in 2000-2001

- caregiving role increasingly demanding/stressful
- 60 individuals waiting for paid respite service as of November 2000 and current clients are waiting for increased hours of service;
- the Regional Municipality of Niagara Seniors Community Programs has submitted a proposal for expansion of its Respite Companion program
- concern that government policy for in-home respite services needs to be consistent across the province; the service should be distinguished from homemaking and volunteer visiting
- concern about government policy to rely on volunteers to provide respite for clients who often have physical care needs and challenging behaviours (e.g., advanced dementia, ABI). Provision of respite services to this client population requires a high level of skill and training and is often required on short notice, and for overnight and weekend respite
- many families become caregivers due to lack of resources available to assist them rather than by choice.

Status of funding recommendations made in previous plans

Total previous recommendations*:	\$ 300,000
Total allocated:	<u>Nil</u>
Balance*:	\$ 300,000

* based on importance of this service in helping caregivers cope with the ongoing burden of in-home care and the lack of resources extant in Niagara

Recommendations

6.2.1 THAT the MOHLTC review its policy to allow the expansion of paid respite services (08C).

- 6.2.2 THAT the MOHLTC, in the absence of a change in government policy to allow expansion of paid respite, allocate up to \$887,500 to allow the CCAC to provide respite services over and above the maximum allowable hours.

6.3 Caregiver Support Services: Training, Information, Education (08B)

Overview of current situation

Three organizations in Niagara are funded by the MOHLTC, , to provide information, education and training which will assist caregivers to provide care and emotional support to individuals needing in-home care and treatment:

- Alzheimer Society of Niagara for caregivers of persons with dementia
- VON Niagara for caregivers of persons with Parkinson's Disease
- Community Services Department of the Regional Municipality of Niagara for caregivers of frail and failing elders

Other organizations provide some information and education for caregivers without specific funding support from the MOHLTC. Examples of these organizations include: the Multiple Sclerosis Society of Canada – Niagara Peninsula Chapter of Hope, the ALS Society, and Epilepsy Niagara.

Issues in 1999-2000 ADSP Update

- existing services stretched to meet demands
- palliative care service providers note need for increased training and education of caregivers of persons living with a terminal illness

Issues in 2000-2001

- important service for physically disabled youth transitioning to adult services (i.e., to inform them in advance of the new range of services they will encounter and to facilitate a seamless transition)
- caregiver role increasingly demanding/stressful

Status of funding recommendations made in previous plans

Total previous recommendations*:	\$ 275,000
Total allocated:	<u>12,500</u>
Balance*:	\$ 262,500

* based on importance of this service in helping caregivers cope with the ongoing burden of in-home care and the lack of resources existent in Niagara

Recommendations

- 6.3.1 THAT the MOHLTC allocate up to \$262,500 to provide expanded caregiver support training, information and education services (08B) for individuals living at home with chronic, degenerative conditions.

6.4 Community Support Services

Overview of current situation

Community Support Services include the following volunteer-based services: meals-on-wheels, friendly visiting, volunteer escorted transportation, security checks and home maintenance & repair services.

Several autonomous organizations provide one or more volunteer-based community support services for particular population groups (e.g., people with acquired brain injuries, individuals with vision impairments, people living with AIDS/HIV, persons with physical disabilities and persons with dementia). Services provided by these organizations are not expected to be affected by the recent formation of a new region-wide alliance.

In 1998, meals on wheels organizations in Fort Erie, Port Colborne, Niagara Falls/Niagara-on-the-Lake and Thorold/St. Catharines formed an alliance with Welland-Pelham Community Support Services, West Niagara Community Support Services and the Regional Municipality of Niagara to work collegially to develop, manage and provide consistent community support services in all areas of Niagara for elderly people and other persons requiring such services. The alliance (known as Niagara Community Support Services) established a Board of Directors consisting of representatives of each of the seven member agencies and received funding support from the MOHLTC to develop policies and procedures which would guide all aspects of the proposed organization's operations. At the present time, two agencies remain in the alliance: Meals on Wheels/Community Support Services Welland/Pelham and West Niagara Community Support Services, have formed Meals on Wheels/Community Support Services.

In addition to providing meal services to their local communities, the new organization will provide other community support services (i.e., home maintenance and repair, friendly visiting and security checks) to the entire region. Four other meals on wheels organizations continue to provide meal services to their local communities. The Canadian Red Cross is the main provider of volunteer transportation in the Region. See Section 6.9 for a discussion of the role of the Regional Municipality of Niagara in the provision of community support services.

Issues in 1999-2000 ADSP Update

- inconsistent availability of services from one community to the next (for example, although all meals-on-wheels organizations are working to make hot meals available at least five days a week, in several communities hot meals still are only delivered 3 days a week)

- escorted transportation is minimally available throughout Niagara and not at all in some communities; the Red Cross has developed a proposal to provide escorted transportation services on a consistent basis for seniors living in areas of Niagara where services are not now readily available
- rapid growth in the need for service particularly due to Niagara's rapidly aging population and hospital patients leaving hospitals quicker and sicker
- strain on existing providers: many existing agencies are struggling to cope with existing service demands
- volunteer recruitment, training and retention pose significant challenges for many organizations
- member agencies of the NCSS alliance which provide meal services are concerned existence of the new alliance not reduce the availability of funding needed to provide adequate meal services in Niagara

Issues in 2000-2001

- all parts of Niagara now have delivery of meals 5 days/week, with the exception of Wainfleet, supplemented by delivery of frozen meals
- opportunities still exist for reduced administrative expenses and more resources directed towards direct service, and standardized services provided
- increased frailty/isolation of clients, increase in number of clients with dementia; with increased needs, more time required to deliver services and for social interaction, for which agencies are not funded; agencies report clients not receiving enough services to meet needs, with cutbacks to CCAC
- transportation for children, the elderly and others with mobility impairments continues to be identified as a key issue across Niagara
- the Canadian Red Cross is experiencing heavy demands for its service
- the CRC is not able to accommodate wheelchair clients
- while not a MOHLTC-funded community support service it is noteworthy in this context to mention Mobility Niagara, which filled a service gap through the provision of cross-boundary (i.e., intra-municipal) transportation to all eligible users in Niagara, including anyone with a cognitive, psychological, visual, developmental or physical disability and anyone 65 years of age or older. In October 1999, Mobility Niagara began an expanded service in which it acted as a broker to arrange/coordinate trips with existing transportation providers during their off-peak hours, 5-6 days/week (previously there had been a more limited service provided on a trial basis). In the first year of operation there were 450 clients registered and an average of 1200 rides per month were provided, compared to an original estimate of 300 rides/month. Despite the demand, the service suspended operations in September 2000 due to funding difficulties. While originally funded through various grants, such as the provincial Community Transportation Action Program and Trillium Foundation and through fundraising, Mobility Niagara is now exploring other business strategies and opportunities and alternative funding sources to ensure ongoing sustainability. One of the avenues being explored includes securing municipal funding for the service; Niagara DHC has requested that municipalities provide financial support to enable Mobility Niagara to resume operations.

Another option being explored includes providing non-ambulance transportation between health care facilities (i.e., hospitals, long term care facilities). The need for such alternative inter-facility transportation is of concern to hospitals and to the Emergency Medical Service, as well as its funder, the Regional Municipality of Niagara Public Health Department. Inter-facility transfers will become an even larger issue upon the eventual rationalization of hospital-based programs across the region with the recent restructuring/amalgamation.

- In the absence of Mobility Niagara, the only accessible transportation services are within the municipal boundaries of St. Catharines (also includes urban Thorold), Niagara Falls and Welland. While criteria for booking varies between the three services, in general terms, the following applies:
 - clients must be registered;
 - bookings must be made in advance for appointments within the next 2-4 weeks;
 - bookings for medical appointments, work and school are given priority over social appointments (although the latter are usually accommodated if client is flexible); and,
 - evening and weekend availability is somewhat limited.
- The 1996 census reveals a higher percentage of elderly people 65 years and older living alone in Niagara compared to the provincial average (28% in Niagara overall and over 30% in some instances versus 27.30% in the province overall). This translates to approximately 19,300 elderly living alone in Niagara in 2000.

Status of funding recommendations made in previous plans

Total previous recommendations:	Total Allocated
All services combined	\$ 1,350,000
(Meal services (02A & 03A)	
Transportation services (04A)	
Friendly visiting services (06A)	
Security checks (07A)	
Home maintenance & repair (05C))	
Total allocated:	\$ 439,514
Balance*	\$ 910,486

* additional funding needed to meet 1995-1996 provincial average service levels based on 1996-1997 service costs and population projections for 1998

Recommendations

- 6.4.1 THAT the MOHLTC allocate up to \$ 400,000 to provide additional community support services, including meal services, friendly visiting, security checks and home maintenance and repair.
- 6.4.2 THAT the MOHLTC support the collaborative efforts of the two member agencies of Meals on Wheels/Community Support Services and encourage remaining four meals on wheels agencies to integrate in order to provide consistent community support services in all areas of Niagara for elderly people and others requiring such services.

- 6.4.3 THAT the MOHLTC allocate up to \$150,000 to provide additional volunteer transportation services to children, elderly people and others with mobility impairments requiring such services.
- 6.4.4 THAT Niagara DHC staff continue to support the efforts of Mobility Niagara to develop a revised business plan and, as appropriate, to secure the necessary funding (e.g., from municipalities, provincial government, etc.) to resume operations.
- 6.4.5 THAT the MOHLTC support a non-ambulance transportation pilot project in Niagara for possible extension as a model in the province.
- 6.4.6 THAT the MOHLTC review its policy and consider including paid transportation as a long-term care community services category eligible for funding.

6.5 Adult Day Services (Seniors) (01A-B-C-E)

Overview of current situation

The Regional Municipality of Niagara, Community Services Department provides adult day services for seniors in various communities across Niagara. For the most part, services are housed in the various long-term care facilities operated by the Regional Municipality of Niagara, while others are housed in locations such as seniors' apartment buildings and shopping malls.

Effective April 1, 1999, Ministry policy changed such that Community Care Access Centres across the province would control admission to seniors adult day services. Community Care Access Centre, Niagara was the first in the province to actually take over this process, and now controls the admission to all 11 adult day programs across the region.

In 1998, the government introduced a new category of adult "day" service: Alzheimer/dementia overnight service for adults with progressive cognitive disorders or dementias of aging.

Issues in 1999-2000 ADSP Update

- access to services hampered by need to travel extended distances to participate in programs operated in other communities (e.g., Thorold to St. Catharines, Pelham to Welland, etc.)
- services not generally available on weekends; family/(informal)caregivers continue to request extended hours and more flexible service arrangements
- requests for service for clients under the age traditionally served
- services minimally available for non-English speaking clients
- requests for service for elders with developmental disabilities due to service down-sizing in other sectors
- one long-term care facility in Niagara (Linhaven) has identified one bed to provide overnight respite for caregivers of adults with progressive cognitive disorders or dementias of aging but

no adult day services are funded to provide overnight accommodation, supervision, meals and activities for adults with progressive cognitive disorders or dementia

Issues in 2000-2001

- 5-day a week programs are not yet a reality at all program sites; some programs have, however, introduced Saturday programs and extended hours
- usage of programs across the region varies and not all programs are currently at capacity – reasons for this might include a unsuitability of group programs for some individuals, issues related to client fees and lengthy transportation rides to attend programs.
- although programs are being developed to meet the needs of particular language/cultural groups (e.g., Francophone in Welland/Port Colborne and Italian in Niagara Falls), further enhancements are required to meet the needs of the diverse language and cultural mix throughout the region
- specialized programming for persons with dementia in the Adult Day Programs is being developed
- need access to services for people with developmental disabilities
- Hospice Niagara has carried out preparatory work for the development of a day program in St. Catharines for palliative care clients (see also Section 6.14).

Status of funding recommendations made in previous plans

Total previous recommendations*:	\$1,000,000
Total allocated from Community funding envelope:	306,677
Balance*:	\$ 693,323
Less: Alzheimer Strategy funding:	<u>\$ 167,231</u>
Balance:	\$ 526,092

* additional funding needed to meet 1995-1996 provincial average service levels based on 1996-1997 service costs and population projections for 1998

Recommendations

6.5.1 THAT the MOHLTC allocate up to \$25,000 to implement a pilot project for an adult day service for palliative care clients.

6.6 Adult Day Services (ABI) (01D)

Overview of current situation

No adult day services for people with acquired brain injuries are currently funded in Niagara by the MOHLTC.

The Head Injury Association of Fort Erie provides a "club house" setting for social, recreational and physical activities planned by and for people living with acquired brain injuries in the greater Fort Erie community.

Anagram Premier provides adult day services (ABI) for a number of specific individuals with acquired brain injuries whose care, treatment and support is funded on a case-specific basis by the MOHLTC.

Issues in 1999-2000 ADSP Update

- organizations serving people with acquired brain injuries and their families emphasize the lack of supervised adult day services as a major gap in Niagara

Issues in 2000-2001

- funding for transportation for ABI clients to access adult day services is problematic

Status of funding recommendations made in previous plans

Total previous recommendations:	\$ 300,000
Total allocated:	<u>NIL</u>
Balance:	\$ 300,000

Recommendations

6.6.1 THAT the MOHLTC, allocate up to \$150,000 to develop and support funded adult day services (01D) for people with acquired brain injuries living in Niagara, with transportation included in the per diem rate.

6.7 **Independence Training (formerly Life Skills) Outreach for ABI (09K) and Physically Disabled Adults (09G)**

Overview of current situation

The MOHLTC introduced this service for ABI during the 1998-1999 budget year and will fund the service for Physically Disabled adults beginning in 2001-2002. The service teaches the activities of daily living and the necessary skills to increase personal independence through working with clients and family members as appropriate. The service includes clients living with families as well as those living in institutions and being prepared for living arrangements in the community.

If an individual is already receiving Homemaking/Personal Support/Attendant Service (SHU12D or 12E), the life skills training is included as part of that service. If the individual is not receiving

Homemaking/Personal Support/Attendant Service but does receive life skills training, then the Life Skills Service 09K is funded as a separate service.

Currently, the MOHLTC funds Niagara Brain Injury Community Re-entry (BICR) to provide this service in Niagara.

Brain Injury Community Re-entry Niagara (BICR) and the Ontario March of Dimes collaborate to provide individualized avocational and pre-vocational programming and supported education and employment programs in group settings for people with physical disabilities and acquired brain injuries. Funding from the Ministry of Community and Social Services supports the Ontario March of Dimes in providing these services. Life Skills (ABI) funding (now Independence Training) supports BICR in providing these services.

Issues in 1999-2000 ADSP Update

- as of February 28 1999, 38 people with acquired brain injuries who had been assessed as eligible and in need of the service were on the BICR wait list for service
- on average, BICR receives 8 to 10 referrals per month for Life Skills training
- service providers report funding from private insurance coverage has become less available to individuals with acquired brain injuries needing rehabilitation and support services since legislative changes were enacted in January 1997; the public system is becoming the first "payer" for such services
- funding support from the Ministry of Community and Social Services for the Ontario March of Dimes collaborative service with BICR (Personal Effectiveness Training) is threatened

Issues in 2000-2001

- the funding from the Ministry of Community and Social Services for the OMOD Contribution Personal Effectiveness Training (PET) program will cease in March 2002
- PET is considered to be very cost effective, with a high degree of respite value for caregivers
- waits for service have existed in the past although no longer maintained given funding uncertainty
- demand for this program perceived to be very high

Status of funding recommendations made in previous plans

Total previous recommendation:	\$ 500,000
Total allocated:	\$ 398,830 +
Balance:	\$ ~ 101,170

Recommendations

- 6.7.1 THAT the MOHLTC allocate up to \$250,000 to provide additional Independence Training - ABI outreach services (09K) to individuals with acquired brain injuries in Niagara.

- 6.7.2 THAT the MOHLTC allocate up to \$150,000 to provide Independence Training for adults with physical disabilities in Niagara (09G)

6.8 Aboriginal Support Service (09X)

Overview of current situation

This service is to be provided by a First Nation, a group of First Nations, or by an Aboriginal Organization to aboriginal clients living off reserve. The purpose is to support their members with information, referral, advocacy and access to mainstream long-term care services such as Community Care Access Centres.

The service is only available to First Nations and other Aboriginal Organizations where other long-term care services such as visiting homemaking/personal support/attendant/respite service, homemaking and nursing services are not provided by the First Nation or Aboriginal Organization.

Issues in 1999-2000 ADSP Update

- Niagara has two Friendship Centres serving aboriginal people living off reserve in the Niagara area; either or both of these organizations may be eligible for funding to provide this service in Niagara

Issues in 2000-2001

- both Friendship Centres were alerted to the availability of this service following development of the 1999-2000 ADSP
- the Fort Erie Native Friendship Centre inquired about the service, but further discussions revealed that they were already providing this type of service as part of their budget from the Ontario Federation of Native Friendship Centres
 - appears to be lack of awareness on the part of some organizations as to the role of the Friendship Centre in assisting Native people
 - securing sufficient numbers of volunteers is a challenge
 - need for culturally-sensitive workers to attend to Native individuals in their homes; at the suggestion of the MOHLTC, the Fort Erie Native Friendship Centre was to explore with the Canadian Red Cross Homemakers, opportunities for Personal Support Workers training for members of the Centre
- the Niagara Regional Native Centre did not pursue accessing this service; it reportedly is not involved in "lifelong care" as is the Fort Erie Centre (which provides Friendly Visiting, Security Checks, Transportation, etc.)
- Welland Metis Council was not approached about service needs of the Native population

Status of funding recommendations made in previous plans

No funding recommendations made in previous plans.

Recommendations

- 6.8.1 THAT the MOHLTC and Niagara DHC share this plan with the two Friendship Centres in Niagara and the Welland Metis Council and work with them as appropriate on issues associated with accessing mainstream long-term care services and need for culturally-sensitive services.

6.9 Client Intervention and Assistance Service (Seniors) (09I)

Overview of current situation

At the time of developing this plan, a review of this service is underway to review and revise existing program guidelines, results of which will be incorporated into the 2002-2003 Planning, Funding and Accountability Policies & Procedures Manual for Long-Term Care Community Services. Until this time, no new service will be funded by the MOHLTC.

Under the current definition, client intervention and assistance services provide intervention and assistance to vulnerable and at-risk seniors. Clients include abused, unmotivated, alienated persons and those not served by other agencies and resources. The goal of the service is to provide support and crisis intervention in critical situations, stabilize and put a plan in place for the longer term. A worker is assigned to assist clients in coping with every day tasks of living in the community, using a case management model.

As noted in the previous plan, the Public Health Department of the Regional Municipality of Niagara obtained grant funding from the Trillium Foundation to pilot a program aimed at working with various business and community organizations to identify vulnerable and at-risk seniors who require intervention and assistance to cope with every day tasks of living in the community. The Gatekeepers Program began operation in Port Colborne in 1998 and expanded to the St. Catharines area in March 1999. Referrals to the Gatekeepers Program currently are sent to the most appropriate agency (typically, Seniors Community Programs, CCAC Niagara, and the Alzheimer Society) based on apparent client needs.

Issues in 1999-2000 ADSP Update

- no organization in Niagara is funded to provide intervention and assistance to persons in need of the service
- agencies, such as the Community Services Department of the Regional Municipality of Niagara, have provided intervention services over the last 15 or more years; historically costs

were absorbed by other funded programs, however, this is no longer an efficient approach to manage the costs of such services

- the mandate of the Public Health Department no longer includes home visits or intervention to this client group

Issues in 2000-2001

- the current definition for CIA does not include the Outreach and Education component of the Gatekeepers program; CIA services are still being provided, particularly by the Community Services Department, but they are not funded for this
- Trillium funding for the Gatekeepers Program will run out in the early part of 2001
- a task force was formed by Gatekeepers to determine how to sustain the program; DHC involvement was requested to assist in the identification of the level of need for client intervention and assistance services
- a new model of service delivery was developed which streamlines the process and builds on the strengths of existing service providers; i.e., CCAC will take on the role of intake and referral to the appropriate agency as an extension of its information and referral function, and the Community Services Department will accept referrals and carry out intervention in cases where service needs are unclear and/or not medically oriented
- in June 2000, the Niagara DHC supported the model, entitled "Integrated Approach to Serving Vulnerable Adults in the Niagara Region" which was submitted to the MOHLTC by Niagara Gatekeepers, Regional Niagara Public Health Department Community Mental Health Program, Regional Niagara Community Services Department, Alzheimer Society of Niagara and CCAC Niagara; at the same time the DHC requested the Long Term Care Committee quantify the future need for CCIA services in Niagara for inclusion in the next ADSP
- the Community Services Department has submitted a proposal to the MOHLTC to act as a sponsor for the new Gatekeepers program; discussions are underway regarding the potential transfer of funding within the Community Services Department from Friendly Visiting Home Maintenance and Repair and Security Checks to CIA (i.e., according to the new service definition under development which could include the outreach/education component needed to identify vulnerable/at risk seniors and connect them to services that will allow them to continue to live safely in the community)

Status of funding recommendations made in previous plans

No funding recommendations made in previous plans.

Recommendations

- 6.9.1 THAT the MOHLTC allocate additional funding of up to \$100,000 to operationalize the new Gatekeepers model in Niagara

- 6.9.2 THAT the Long Term Care Committee continue to work with the Community Services Department/Gatekeepers Program to monitor service volumes and trends with respect to Client Intervention and assistance

6.10 Homemaking/Personal Support/Attendant/Respite Services (Adults with disabilities) (12B)

Overview of current situation

Services are provided to persons over the age of 16 with permanent physical disabilities who require assistance with the activities of daily living and have the ability to direct an attendant to carry out pre-determined tasks that the individual cannot do for him/herself.

The Ontario March of Dimes provides homemaking/personal support/attendant/respite services (12B) to adults in Niagara with physical disabilities.

The March of Dimes provides supportive housing services for students in residence at Brock University and Niagara College.

Issues in 1999-2000 ADSP Update

- as of December 18, 1998, 72 adults in Niagara with disabilities had been assessed as eligible for service and were on the "wait list" maintained by the Ontario March of Dimes
- increasing numbers of clients with degenerative diseases and aging consumer base is increasing the proportion of "heavy care"
- more consumers are being identified with cognitive impairments requiring ongoing assessment with respect to their ability to direct their own care
- increasing numbers of requests for service for persons who do not meet priority eligibility criteria implemented by CCAC Niagara

Issues in 2000-2001

- as of November 2000 there is a wait list of 85, which is expected to be reduced to approximately 60 with recent expansion funding. In additions there are 74 applications for services pending. (Note: It is estimated that close to \$1 million in additional funding would be needed to support 75 new consumers many of whom have been on the waiting list for more than one year.)
- long waits for attendant care services tend to increase the demand on CCAC services
- competition for personal support workers
- Ontario March of Dimes striving to create full time positions and maintain service stability (i.e., attract workers/decrease turnover) by combining outreach and supportive housing service centres; also working with CCAC to decrease number of providers/client

- The Arthritis Society Consultation and Rehabilitation Service (not funded from community long term care envelope) sees many clients who would benefit from these services but there are insufficient services available
- Need access to services for people with developmental disabilities

Status of funding recommendations made in previous plans

Total previous recommendations:	\$ 600,000
Total allocated:	<u>810,194</u>
Balance:	(over by) \$ 210,194

Recommendations

- 6.10.1 THAT the MOHLTC, allocate up to \$500,000 to expand and enhance homemaking/personal support/attendant respite (adults with disabilities) service (12B) in Niagara to (partially) meet the needs of those on the wait list for service.

6.11 Visiting Supportive Living Service (ABI) (12E)

Overview of current situation

This service (12E) provides the core components of attendant service (homemaking/personal support) for persons with acquired brain injuries. In addition, the service includes the Life Skills (ABI) service (see 6.7) as well as the implementation of client specific behavioural management programs developed and/or supervised by the professional service funded through the Psychological (ABI) services (see 6.15)

Brain Injury Community Re-entry Niagara (BICR) provides this service to adults in Niagara with acquired brain injuries.

Anagram Premier provides visiting supportive living services for a number of specific individuals with acquired brain injuries whose care, treatment and support is funded on a case-specific basis by the MOHLTC.

Issues in 1999-2000 ADSP Update

- as of February 28 1999, 3 people in Niagara with acquired brain injuries had been assessed as eligible for service and were on the "wait list" maintained by BICR

Issues in 2000-2001

- no new issues identified

Status of funding recommendations made in previous plans

No specific funding recommendations made in previous plans.

Recommendations

No new allocation at this time.

6.12 Self-Managed Attendant Service - Direct Funding (12H)

Overview of Current Situation

Self-Managed attendant service (direct funding) is an innovative program which enables eligible adults with physical disabilities across Ontario to receive funds individually to recruit, manage and pay for their own attendants, i.e., to become an employer with all the associated responsibilities of being an employer. There is also the option to broker the services through an existing agency and to hire a manager to handle employer related responsibilities. The program is funded by the Ontario MOHLTC and is administered by the Centre for Independent Living in Toronto (CILT) in partnership with the Ontario Network of Independent Living Resource Centres (ONILC).

Potential clients should contact either:

- Niagara Centre for Independent Living at 1-800-263-3695; or,
- The Centre for Independent Living in Toronto at 1-800-354-9950, fax (416) 599-3555
e-mail cilt@cilt.end.com.

Issues in 1999-2000 ADSP Update

- many service providers and potentially eligible adults with physical disabilities are unaware of the availability of this service and how to access it

Issues in 2000-2001

- no new issues identified

Status of funding recommendations made in previous plans

No funding recommendations made in previous plans.

Recommendations

- 6.12.1 THAT the MOHLTC continue to publicize the availability of the self-managed attendant service and identify organizations in communities across Ontario to respond to questions from interested people and support individuals in accessing the service.

6.13 Visiting Professional Services and Visiting Homemaking/Personal Support/Respite Services

Overview of current situation

Professional services include: nursing (15A), physiotherapy (16A), occupational therapy (17A), social work (18A), speech language pathology (19A), dietetics (20A), long-term care facility placement coordination (14A) and case management (13A).

Visiting professional services and visiting homemaking/personal support/respite services (10A) are offered through Community Care Access Centre Niagara for children and adults requiring in-home care and treatment following hospitalization or as a result of continuing physical and/or functional impairment. CCAC Niagara purchases services, on behalf of clients, from several different agencies.

As well, Brain Injury Community Reentry Niagara Inc. (BICR) is funded by the MOHLTC to provide visiting social work for people in Niagara with acquired brain injuries. BICR provides support and counselling for individuals, their families and caregivers.

The Ontario March of Dimes has also received funding for a social worker to help serve physically disabled consumers, particularly those with complex care needs and/or are at high risk.

Issues in 1999-2000 ADSP Update

- creation of CCAC Niagara as an independent, autonomous organization required allocation of ongoing funding for human resource, financial, program and information management supports
- revised admission criteria and utilization strategies initiated late in 1997 continue in effect; anecdotal evidence indicates the changes may have led to increased hospital admissions of elderly consumers, more patients in hospital waiting placement in long-term care facilities and greater financial, physical and emotional burdens on caregivers
- inappropriate admissions to acute care facilities occurring due to inability to provide adequate supports to maintain individuals in the community
- as of February 28 1999, 167 school-age children were waiting for occupational therapy
- as of February 28 1999, 399 school-age children were waiting for speech and language pathology services; the shortage of speech and language pathologists (SLPs) in the province and the shift of available SLPs into the pre-school speech and language initiative has contributed to a dramatic growth in the size of the wait list this year
- caseloads increased to average of 125 clients/case manager
- restrictive utilization strategies raising concerns about the ability to ensure safety/security of consumers in their homes through monitoring of health status by contracted service providers
- insufficient supports available from other agencies (e.g., community support services) for individuals not meeting CCAC Niagara's current eligibility criteria
- the HSRC report on Niagara recognizes there will be a need to expand visiting professional and visiting personal support/homemaking services in the community to handle expected

changes in hospital activity; the final directions indicate Niagara will require a reinvestment of \$6 million for the in-home care of patients following inpatient hospitalization but timing is an issue

- the timing of the reinvestment is "by the year 2003"; in the meantime significant hospital changes are already occurring; CCAC Niagara is barely able to cope with the current demand for services, particularly visiting homemaking

Issues in 2000-2001

- CCAC Niagara has implemented extended hours for accepting and acting on referrals from hospitals and community service providers
- need continues to outstrip demand; the frail elderly who are in need of homemaking services in order to remain in their homes, are not being served
- the HSRC recommendations for additional long term care places have not been addressed
- with new funding, CCAC Niagara anticipates it will be able to maintain 1999-2000 service levels, despite growth projections
- waits for School Health Support Service continue; although reduced temporarily due to concerted effort in 1999, waits as of November 30, 2000 have increased since the previous plan to a total of 829 (breakdown as follows: physiotherapy 54, occupational therapy 248 and speech language pathology 487). (Note: The CCAC has developed an estimate of \$1.6 million in purchased (therapy) services alone (i.e., without considering the additional case management costs) required to serve all of the children currently on the SHSS wait list until completion of their treatment. It is anticipated it will take a few years to reduce the waits to more reasonable levels given the availability of therapists in the community.)
- CCACs across the province will now be serving children in private schools, which has both therapy and case-management related costs/pressures
- hospitals are noticing the same frail elderly clients are being re-admitted. These clients, many of whom live alone, require homemaking support to enable them to remain in their own homes and avoid crisis situations.

Status of funding recommendations made in previous plans

Total previous recommendations*:	\$ 6,000,000
Total allocated:	9,043,871
Balance:	(over by) \$ 3,043,871

* based on information about 1995-1996 service levels in Niagara relative to other areas of the province; 1994-1995 hospital utilization patterns and 1996 government policy direction

Recommendations

- 6.13.1 THAT the MOHLTC allocate the full amount of funding identified by the Health Services Restructuring Commission (HSRC) in its final report on Niagara. Specifically, allocate an additional funding needed to provide in-home long-term care and support "places" consistent with HSRC directions.

6.13.2 THAT the MOHLTC allocate \$500,000 to the CCAC for a pilot project specifically to serve the frail elderly, to improve their quality of life in their own homes.

6.13.3 THAT the MOHLTC review CCAC School Health Support Services and allocate up to \$500,000 to begin to address the very large wait list for services.

6.14 Palliative Care Services

Overview of current situation

Visiting nursing and visiting homemaking/personal support services for persons living at home with a terminal illness are provided as part of the visiting services offered through CCAC Niagara.

Other palliative care services funded by the MOHLTC, include: visiting hospice volunteer services (08D); pain & symptom management consultation services (24A); interdisciplinary education for volunteers and front-line health care staff of community agencies and long-term care facilities (23A); and, education for physicians in palliative care (22A).

In Niagara, the following organizations are funded to provide visiting hospice volunteer services:

- West Niagara Community Palliative Care Service, serving residents of Grimsby, Lincoln and West Lincoln
- Niagara-on-the-Lake Community Palliative Care Service, serving residents of Niagara-on-the-Lake
- Hospice Niagara, principally serving residents of St. Catharines and Thorold although accepting referrals from residents in any area of Niagara when service would not otherwise be available.

In addition, visiting volunteer services are also offered persons living at home with a terminal illness by the following organizations without funding from the Ministry's Long-Term Care Division:

- Welland County General Hospital, serving residents of Welland
- Greater Niagara General Hospital, serving residents of Niagara Falls
- Port Colborne General Hospital, serving residents of Port Colborne
- Greater Fort Erie Community Palliative Care Service, serving residents of Fort Erie.

Hotel Dieu Health Sciences Hospital, Niagara coordinates pain and symptom management consultation services provided by a volunteer team of specialists in palliative care. The service provides expert medical, nursing, psychological and pastoral advice to other service providers throughout Niagara.

Since 1998 Hospice Niagara has accepted responsibility for administering the annual funding provided for interdisciplinary training in palliative care. A MOHLTC formula determines funding available to all long-term care facilities, visiting hospice volunteer service agencies, CCAC Niagara and visiting professional, homemaking and personal support organizations.

The MOHLTC funds physician palliative care education in Niagara through the Continuing Medical Education (CME) program of the Faculty of Health Sciences, McMaster University. The CME program uses the funding to support training of physicians practising in Hamilton-Wentworth, Niagara, Brant and Haldimand-Norfolk.

Issues in 1999-2000 ADSP Update

Organizations funded by the Long-Term Care Division to provide palliative care services in Niagara included the following issues in their 1998-1999 service plans:

- visiting volunteers need training in specialized areas (e.g., positioning, lifts and transfers, etc.)
- increasing referrals as families strive to cope with complex care and high levels of emotional stress
- night caregivers needed
- need for crisis support on a 24-hour basis
- need hospice as alternative for those providing terminal care at home but not needing acute treatment in hospital setting
- increasing referrals from long-term care facilities for pain and management consultation

Issues in 2000-2001

- need for palliative care services continues to grow
- increased referrals for pain and symptom management attributed to community palliative care rounds being held in several communities in the region (and expanding to others); however, need for enhanced communication of service availability identified
- role of volunteers, and hence the need for specialized training, is not consistent across all volunteer visiting organizations
- more male/female volunteer teams are being recruited to support couples who are both coping with life-threatening or chronic/debilitating conditions
- need for improved coordination of services identified
- visiting hospice providers report increase linkages with long term care facilities
- In May 1999, Niagara DHC supported the efforts of the Salvation Army to develop a residential hospice on the site of Eventide Home for the Aged in Niagara Falls
- Trillium Foundation funding was acquired by Hospice Niagara to hire a Project Developer (April 2000) for up to a two-year period to promote residential hospices in Niagara and develop a funding strategy
- a change in government legislation is required to staff a residential hospice with professional nursing services
- the Project Developer is also looking into the concept of a Day Hospice, such as those operating in Ottawa, Windsor and Calgary; however, similar to residential hospices, there is no Ministry policy for this type of service (see also section 6.5 re: pilot project)
- a new cancer support centre for cancer patients and their families is being developed in Niagara; the service known as "Wellspring Niagara", is being modelled after centres in Toronto and Hamilton. In offering social, emotional, informational and spiritual support to

cancer patients and their families, the service is intended to complement existing cancer care services in Niagara

Status of funding recommendations made in previous plans

	<u>Total Previous Recommendations</u>	<u>Total allocated</u>	<u>Balance</u>
Visiting hospice volunteers	\$ ~140,000	\$ 56,575	\$ 83,425
Pain & symptom management	110,000	NIL	\$ 110,000
Interdisciplinary education	NIL	NIL	NIL
Physician education	<u>NIL</u>	<u>NIL</u>	<u>NIL</u>
All services combined	\$ 250,000	\$ 56,575	\$ 193,235

Recommendations

- 6.14.1 THAT the MOHLTC allocate up to \$200,000 to provide additional palliative care services consistent with the balance of previous funding recommendations remaining unallocated for each defined service (08D, 24A).
- 6.14.2 THAT the MOHLTC proceed quickly to identify a policy framework within the MOHLTC to support the funding and operation of residential hospices to meet the growing need for alternative approaches to caring for persons living with a terminal illness who do not need treatment in a hospital setting
- 6.14.3 THAT the Niagara DHC work in conjunction with Hospice Niagara to assess the need for Day Hospice Services in Niagara. Include in this analysis the fit between day hospice and adult day services as currently defined by the MOHLTC and focus group discussions to be held in early 2001.
- 6.14.4 THAT the Niagara DHC work with existing palliative and cancer care services in Niagara to determine how the new Wellspring Niagara cancer support service fits into the spectrum of services.

6.15 Psychological Services (ABI) (21A)

Overview of current situation

Brain Injury Community Re-entry Niagara (BICR) is funded to provide psychological services for individuals which ameliorate inappropriate behaviour and/or train new skills or support the reacquisition of lost skills. Services are provided to clients of BICR. These services were previously defined as "Behaviour Management Therapy (ABI)". In 1998, BICR received new funding to expand to a full-time (i.e., 5 day a week) service.

Anagram Premier provides psychological services (ABI) to support a number of specific individuals with acquired brain injuries whose care, treatment and support is funded on a case-specific basis by the MOHLTC.

Issues in 1999-2000 ADSP Update

- full-time service initiated by BICR in February 1999 is expected to meet current demands for service

Issues in 2000-2001

- no new issues identified in relation to this service

Status of funding recommendations made in previous plans

Total previous recommendations:	\$ NIL
Total allocated:	<u>NIL</u>
Balance:	NIL

Recommendations

No additional allocation at this time

6.16 Special Services for the Blind and Visually Impaired (25A)

Overview of current situation

The Canadian National Institute for the Blind (CNIB) provides services for blind and visually impaired persons living in communities throughout Niagara. Services offered include orientation and mobility training; vision rehabilitation; advice and training about the use of technical devices; and, information and counselling for individuals and their families on issues related to vision loss.

Issues in 1999-2000 ADSP Update

- tremendous demands for service over the past few years
- 77% of clients are age 65 or over
- one in nine persons over the age of 65 experiences a loss of vision that cannot be remediated with the use of corrective eye wear
- with existing client to staff ratio of 401 clients to 1 staff member (direct service), turnaround times for support are lengthy

Issues in 2000-2001

- no new issues identified; new funding does not fully address previous service expansion requirements

Status of funding recommendations made in previous plans

Total previous recommendations:	\$ 62,000
Total allocated:	<u>50,000</u>
Balance:	\$12,000

Recommendations

- 6.16.1 THAT the MOHLTC allocate up to \$12,000 to support further expansion of special services for the blind and visually impaired (25A) to meet the growing need for services for the blind and visually impaired.

6.17 Special Services for Persons with Acquired Hearing Loss (26A)

Overview of Current Situation

As of November 1998, the Canadian Hearing Society (CHS) established a Niagara area office. CHS services offered Niagara residents 55 and older who have a hearing loss include: home visits, information/counselling for individuals' and their families on issues related to hearing loss, training in strategies that can make communication easier, orientation in how to use hearing aids and information/training regarding the use of technical devices. The CHS also provides in-service training about hearing loss for professionals and others who work with seniors.

Issues in 1999-2000 ADSP Update

- service began operations in November 1998 and is in the process of building connections with other agencies in Niagara to develop referral network
- it will take at least one year of operation to assess the extent of need for service in Niagara able to be met with new resources
- access to health system (e.g., hospitals, physicians, etc.) is problematic for individuals who are profoundly deaf and rely on sign language interpreters

Issues in 2000-2001

- with aging population, rapidly growing incidence of hearing loss
- at least 50% of all seniors receiving any type of service have hearing loss
- need for "mainstream" service providers to understand special needs of clients

- one-on-one and group services have expanded in Niagara but service at capacity and wait lists exist
- accessible services to culturally deaf seniors (i.e., signing) remains an unmet need

Status of funding recommendations made in previous plans

Total previous recommendations:	NIL
Total allocated:	<u>NIL</u>
Balance:	NIL

Recommendations

- 6.17.1 THAT the MOHLTC allocate up to \$50,000 to meet growing demands for services for people with acquired hearing loss.

6.18 Supportive Housing

Overview of current situation

Supportive housing programs provide on-site homemaking/personal support services, with the personal support component available 24 hours a day, where there are enough individuals in the program who require enough care to justify the availability of 24-hour personal support service at a cost-effective level. At the present time supportive housing services provide at least 16 hours coverage (one providing 24 hour coverage) with some form of emergency response and /or security checks at night. CCAC provides professional care services for eligible clients in supportive housing facilities.

Supportive housing services for elders (SHU 11A) in Niagara are provided by several Charitable Homes for the Aged as well as by the Regional Municipality of Niagara Community Services Department. The following Charitable Homes for the Aged offer supportive housing programs for residents of apartment complexes managed by the respective organization:

- Heidehof
- Tabor Manor
- Niagara Ina Grafton Gage
- Pleasant Manor
- United Mennonite Home.

Niagara Ina Grafton Gage also provides supportive housing services for residents of the Fairhaven Seniors Apartments in Niagara Falls. The Region provides supportive housing services in "satellite homes" associated with the Municipal Homes for the Aged located in various communities around Niagara.

Supportive housing services for adults with physical disabilities (SHU 12A) are provided by the Ontario March of Dimes at four locations in Niagara. Tanguay Place provides supportive housing services for adults with complex physical disabilities living in a purpose-built residential facility.

Supportive housing services for people with acquired brain injuries (SHU 12D) are provided at five locations in Niagara by Brain Injury Community Reentry Niagara (BICR). In addition, Anagram Premier provides supportive housing services at two locations for a number of specific individuals with acquired brain injuries whose care, treatment and support is funded on a case-specific basis by the MOHLTC.

AIDS Niagara provides supportive housing services for people in Niagara with HIV/AIDS (SHU 12F).

Issues in 1999-2000 ADSP Update

Supportive housing for seniors

- population more frail with more complex care needs
- increased support and follow-up required for psychosocial and behavioural concerns
- demands for increased service levels from individuals already receiving service and from their family members
- services not available in many large seniors housing complexes across Niagara

Supportive housing for adults with physical disabilities

- as of December 1998, 72 applicants waited on the list for admission to supportive housing programs provided by the Ontario March of Dimes
- unavailability of appropriate subsidized, accessible housing space

Supportive housing for people with acquired brain injuries

- as of February 28 1999, 19 applicants waited on the list for admission to supportive housing programs provided by Brain Injury Community Re-entry
- no supportive housing services are available for persons with acquired brain injuries who are minimally responsive to external stimuli

Supportive housing for people with HIV/AIDS

- establishing and maintaining extensive links needed with other community services (e.g., Niagara Alcohol and Drug Assessment Service, Detox, etc.)
- specialized training for staff and volunteers (e.g., harm reduction, substance abuse, addictions, etc.)
- addressing needs of low income clients
- monitoring medical issues

Issues in 2000-2001

Supportive housing for seniors

- wait lists exist; insufficient units available; economies of scale are important in adding/converting units
- need to improve supportive housing services to older adults with mental health, psychosocial and behavioural concerns over and above their physical support requirements
- some clients require supports beyond the scope of supportive housing
- further education required on level of care available in supportive housing

Supportive Housing for adults with physical disabilities

- as of November 2000, 73 applicants are waiting for admission to supportive housing, with an additional 39 applications pending
- There is a need for capital funding to renovate facilities for supportive housing for the physically disabled (e.g., potential facility in Welland)
- in the absence of available housing, need creative solutions, e.g., "virtual supportive housing", with scheduled visits as opposed to 24 hour care
- new admissions now include clients with heavier care requirements (e.g., transferred directly from hospital settings), impacting on resource availability

Supportive Housing for people with acquired brain injuries

- waits for service exist
- 45% of clients multi-diagnosed, including addictions, but difficulty accessing mental health services
- recruitment of staff/turnover problematic

Supportive Housing for HIV/AIDS

- availability of staff resources problematic both in terms of maintaining extensive linkages and in dealing with the complexity of the population
- service expansion received in 2000 from 9 to 12 units

Status of funding recommendations made in previous plans

Total previous recommendations:	\$ 2,500,000
Total allocated:	<u>1,059,756</u>
Balance:	\$ 1,440,244

Recommendations

- 6.18.1 THAT the MOHLTC allocate up to \$300,000 to expand and enhance the availability of supportive housing services for seniors (SHU 11A), adults with disabilities (SHU 12A) and people with acquired brain injuries (SHU 12D).

- 6.18.2 THAT the MOHLTC identify a policy framework within the MOHLTC to support the funding and operation of residential services to meet the needs of persons with acquired brain injuries who are minimally responsive to external stimuli (e.g., proposal from Headway Homes)
- 6.18.3 THAT the MOHLTC provide capital funding and government policy support to build and/or renovate accessible, subsidized housing units for seniors, people with physical disabilities, and adults with acquired brain injuries.
- 6.18.4 THAT the MOHLTC support AIDS Niagara in working with other agencies in Niagara to help staff meet the particular needs of residents receiving supportive housing services.

6.19 Children's Treatment Centre Services

Overview of current situation

Niagara Peninsula Children's Centre (NPCC) provides a range of services to children and their families at its main location in St. Catharines, at satellite locations in Fort Erie and Grimsby and in other community settings (e.g., day care centres, etc.) as well as in individual children's homes in certain situations. Services provided by the Centre include: occupational therapy (81A), physiotherapy (82A), speech and language pathology (83A), social work (84A) and augmentative communications (90A). New Services in 2000-2001 include Seating (88A) and Medical Services (92A).

Since 1998, NPCC has acted as the Lead Agency for the Pre-School Speech and Language initiative. NPCC partners with other agencies which deliver pre-school speech and language services to provide early identification and treatment in pre-schoolers with speech and/or language delays (originally 5 agencies, now 3, due to transfer of funding for preschool SLP from 2 organizations to NPCC).

Issues in 1999-2000 ADSP Update

- funding levels frozen for several years pending provincial review of all Children's Treatment Centres across the province
- number of children referred and receiving service exceeds expectations; without corresponding staffing increases, the Centre is concerned that the level of service may be compromised
- NPCC is particularly concerned about increasing numbers of clients needing therapy as a result of both the Healthy Babies and Pre-School Speech and Language initiatives
- wait list for all services: 316 children in 1998

- with appropriate funding, some NPCC services for children (e.g., augmentative communications, seating and gait analysis clinics) could be enhanced to meet identified needs for these services in the adult population

Issues in 2000-2001

- following the provincial review of Children's Treatment Centres in 1999, the MOHLTC announced \$4 million for all CTCs across the province in late 1999; allocations were made in September 2000
- the new allocation to NPCC is not sufficient to stabilize the current service load, including existing caseloads which do not comply with minimum professional standards and waits for service; as of the end of September, 2000, there were 319 children on the waiting list, including 220 for speech and language services, and the balance for OT, PT, Social Work, Augmentative Communication and various clinics.
- resources are not available to provide after school programs for children with special needs
- increase in early identification of children at risk through Healthy Babies/Healthy Children and Preschool Speech and Language initiative is resulting in more children needing speech and language services and also those requiring other therapies, for which insufficient resources exist.
- families are becoming more involved in care plan development and implementation
- new adult referrals for Augmentative Communication Services were discontinued in the Fall of 2000 meaning this service is not available for adults in Niagara

Status of funding recommendations made in previous plans

Total Previous recommendations:	Nil
Total allocated	\$246,041

Recommendations

- 6.19.1 THAT the MOHLTC allocate up to \$250,000 to meet the serious service pressures and long waits for services being experienced by children with physical or communicative disabilities.
- 6.19.2 THAT the MOHLTC review its policy and allocate up to \$160,000 for the Niagara Peninsula Children's Centre to resume and expand augmentative communication services for adults.

6.20 Other Service Issues/Recommendations (not associated with long term care community service categories)

In September 2000 the Long Term Care Committee was asked by NDHC to review the document of the Ontario Community Support Association, entitled, The Effect of the Managed Competition Model on Home Care in Ontario: Emerging Issues and Recommendations, June 2000. The Ontario

Association of Community Care Access Centres' position paper of July 2000, Human Resources: A Looming Crisis in the Community Care System in Ontario, was also reviewed given it deals with similar issues. The Long Term Care Committee decided to pursue this by assessing the issues associated with managed competition as well as the extent of human resource shortages at the local level. At the time of writing, data is being compiled to support this review process.

Recommendations

- 6.20.1 THAT the MOHLTC continue its review of the managed competition model.
- 6.20.2 THAT the MOHLTC support the need for additional emphasis on and additional training places for professional and community support service providers to meet expanding needs.
- 6.20.3 THAT the Long Term Care Committee proceed with assessing the issues associated with managed competition as well as the extent of human resource shortages at the local level.

6.21 Priorities

While acknowledging the need for the full spectrum of services in Niagara, the Long Term Care Committee came up with the following recommendations on how the foregoing funding recommendations should be prioritized by the MOHLTC.

Recommendations

- 6.21.2 THAT the MOHLTC fund services requiring comparatively smaller funding allocations of \$100,000 or less, specifically:
 - client intervention and assistance (Rec. 6.9.1);
 - adult day services for terminally ill clients (Rec. 6.5.1);
 - services for the blind and visually impaired (Rec. 6.16.1); and,
 - services for persons with acquired hearing loss (Rec. 6.17.1).
- 6.21.3 THAT the MOHLTC give priority to the urgent need to address the following:
 - transportation, both volunteer and alternative models (Recs. 6.4.3, 6.4.5 and 6.4.6);
 - caregiver respite services through paid services or protected CCAC services (Recs. 6.2.1 and 6.2.2); and,
 - CCAC services, especially for the frail elderly and school health support services (Recs. 6.13.2 and 6.13.3).

7 LINKAGES, SERVICE COORDINATION AND HEALTH CARE RECONFIGURATION

This section describes issues and planned actions with respect to how the long-term care community service system links and coordinates with other parts of the health and social services system, and other sectors such as hospital restructuring and community mental health initiatives to ensure a continuum of long-term care services.

Opportunities for cross-sector training and collaboration are fundamental to making services work in Niagara.

7.1 Linkages and Service Coordination

A variety of forums exist in Niagara for information sharing and collaborative action involving community service providers. These include:

- service specific local networking groups, for example, meals-on-wheels coordinators, visiting professional service providers, supportive housing for seniors providers, etc.
- issue/cause specific local groups, for example, Mobility Niagara, Head Injury Associations (Niagara, Fort Erie), Elderly (Mental Health) Outreach Group
- cross issue/cross service sector local networking groups, for example, Niagara Community Partnerships (primarily health service providers), Community Partners (primarily social services providers)
- ad hoc issue specific local groups, for example, Niagara Falls and St. Catharines Mayors' Committees for people with disabilities
- ongoing relationships-meetings between individual service providers, for example, CCAC Niagara/Ontario March of Dimes (although case management specific meetings have continued, need identified to re-establish biannual meetings) and Niagara Peninsula Children's Centre with its community partners
- information sharing forums (e.g., CCAC)
- the Niagara Health System is exploring development of acute care liaison nurses to follow up with high risk clients out into the community
- visiting hospice providers report increase linkages with long term care facilities (e.g., training of volunteers/visiting)

The 1999-2000 ADSP provided an overview of initiatives in Niagara to achieve enhanced service coordination:

- Council's Long-Term Care Committee invited service providers from various settings (i.e., community, hospital, residential), physicians and others to separate meetings to explore

interest in creating ongoing forums for information sharing and collaboration on areas of common concern related to services for frail seniors, children and people with disabilities

- organizations providing palliative care services for people living with a terminal illness in Niagara established a district-wide coordinating body
- organizations providing volunteer-based community support services to seniors across Niagara formed a new alliance to coordinate service development.

An update on these specific initiatives is provided below, followed by additional developments over the past 18 months.

7.1.1 Coordinating services for children

As noted in the previous plan, in early 1999, a group of MCSS and MOHLTC funded agencies involved with serving children requiring services in the home met on a couple of occasions. They identified the following key issues for action:

- children's needs must be recognized and there must be equitable funding for children based on these needs
- the MOHLTC and the Ministry of Community and Social Services should work closely together to ensure streamlining and reduce fragmentation of services
- there should be a single point of access to services for all people regardless of their age or disability
- common assessment tools need to be used across sectors to assess the entire person (i.e., physical, mental, developmental, social needs, etc.)

The group recommended that a local task group be formed, connected with and supported by the District Health Council, to further explore the above key issues, and also to identify needs locally for children's services. However, before the group was brought together to develop specific terms of reference for consideration by the DHC, an RFQ was issued by the MOHLTC and MCSS for community initiatives to better organize and deliver services to medically fragile and technologically dependent children being cared for at home (July 1999).

DHC staff participated in the development of a submission for Niagara. CCAC Niagara and Niagara Community Services Council were identified as sponsors and Niagara DHC as a partner, along with MCSS, MOHLTC, NPCC, Niagara Support Services and Associations for Community Living (St. Catharines, Grimsby/Lincoln, Welland, Port Colborne, and Fort Erie. Niagara, one of 12 areas responding to the RFQ, was not chosen. The successful communities, announced in December 1999, are Halton-Peel, Ottawa, Simcoe County and Thunder Bay. These pilots, currently underway, are intended to eventually benefit all communities; as the pilots will address the same issues as had been identified locally, the formation of a local task force was not pursued any further.

7.1.2 Coordinating services for people with physical disabilities

As noted in the previous plan, in mid-late 1998, a number of agencies serving adults with disabilities met on several occasions to discuss coordination of services for people with disabilities. Key issues included:

- inadequate understanding of the philosophies, approaches and services of different providers
- difficulty in stepping "outside" defined service models
- numerous funding sources (e.g., MOHLTC, Ministry of Community and Social Services, local government income support programs, Ministry of Transportation, etc.) Create problems in making services consistent
- inconsistent understanding of who is "the" case manager particularly for those needing service from multiple providers and from different sectors
- rigid diagnosis-based criteria to determine eligibility for services

The group decided to establish a task force to investigate potential models of co-ordination and prepare recommendations for consideration by providers of services to persons with disabilities and asked that Council's Long-Term Care Advisory Committee sponsor the work of the task force. While the Long Term Care Advisory approved the Terms of Reference, resource issues have not enabled the actual formation of the Task Force, as determined through the DHC Operating Plan process.

Services to clients with Multiple Sclerosis have been regionalized within Niagara (now known as the Multiple Sclerosis Society of Canada - Niagara Peninsula Chapter of Hope).

7.1.3 Coordinating services for frail seniors

Similarly, as noted in the previous plan, in mid-late 1998, representatives from a large number of organizations met to discuss coordination of services for frail seniors. A survey of Niagara area service providers revealed minimal interest in creating a special forum. Survey responses noted that many organizations already meet on their own (e.g., long-term care facilities, hospital discharge planners, etc.) and that several agencies already participate in Niagara Community Partnerships, a well-established forum for information sharing. In November 1998, the Community Partnerships group decided to expand its invitation list to include long term care facilities and all community based agencies funded by the MOHLTC. Members also agreed to include information sharing and education specifically related to providing services for frail seniors as part of their ongoing activities. While this group experienced a period of hiatus, it was reactivated in September 2000, and reconfirmed its Mission as follows:

"Niagara Community Partnerships is a dynamic partnership initiated to foster communication and to share information between caregivers and multi-service professionals who work for individuals living with the effects of a disability or

who suffer from interruption affecting their activities of daily living. By sharing knowledge through educational presentations, the partnerships will be enhanced thereby improving the quality of care and services. “

7.1.4 Coordinating palliative care services

In May 1998, the Niagara Regional Palliative Care Organization (NRPCO) was formed. The formation of NRPCO was recommended in Council's report *An Integrated Network of Palliative Care Services for Niagara*. That report identified several issues related to the care and support of individuals living with a terminal illness in Niagara, including:

- poor communication about clinical issues between various service providers
- physician reluctance to refer for pain and symptom control
- low level of community awareness of palliative care
- lack of sufficient funding and resources in the community to support people (e.g., nursing, homemaking visits, respite for caregivers in the home)
- lack of timely referrals (i.e., to prevent crisis situations)
- lack of hospice facilities
- lack of clarity about who is responsible for co-ordinating care for people living at home
- lack of incentives for physicians to care for people at home
- lack of a central organizing body (i.e., an “umbrella” co-ordinator over all services)

As an independent coordinating organization for palliative care in Niagara, NRPCO is providing specific clinical and administrative supports to coordinate the various direct service providers operating within Niagara. The NRPCO Board of Directors has By-Laws, a Vision and a Mission Statement in place. It is working to fundraise/seek funding to support its operations, including sponsoring/organizing another educational day in the Spring of 2001. NRPCO is also working with Hospice Niagara to share office space and bilingual support staff. A need has been identified in the community to clarify NRPCO's role.

7.1.5 Coordinating volunteer-based community support services

As noted in the previous plan, in July 1998, a group of local community support service agencies submitted a joint report to the MOHLTC on a proposed structure for development and delivery of volunteer-based community support services in Niagara.

The proposed structure is designed to ensure the delivery of consistent, quality community support services equally accessible to all residents of Niagara. It includes:

- forming a new organization, Niagara Community Support Services (NCSS), as an alliance of the seven organizations which developed the report

- NCSS would be accountable for developing, managing and providing community support services in all areas of Niagara for elderly people and other persons requiring such services;
- the seven member organizations of the alliance would continue to function as autonomous, non-profit organizations; each would be accountable to NCSS to provide one or more volunteer-based community support services for residents living in particular communities.

In November 1998, the alliance established a transitional Board of Directors consisting of representatives of each of the seven member agencies and received initial funding support from the MOHLTC to develop policies and procedures which would guide all aspects of the proposed organization's operations. Subsequently, the boards of four of the meals on wheels agencies withdrew from the transitional Board. Two agencies, Meals on Wheels/Community Support Services of Welland Pelham and West Niagara Community Support Services are now in the process of amalgamation. The intent is for this new agency, Meals on Wheels/Community Support Services, to provide home maintenance and repair, friendly visiting, and security checks throughout Niagara, while the remaining meals on wheels organizations continue to provide meals (and to a limited extent home maintenance and repair) within their local communities. The Canadian Red Cross is the designated provider of volunteer transportation in the region. The Regional Municipality of Niagara Community Services Department has already discontinued provision of volunteer transportation and is undertaking discussions with the MOHLTC to discontinue providing other community support services (including home maintenance and repair, friendly visiting and security checks) and in their place, provide client intervention and assistance.

7.2 Hospital Reconfiguration

The following excerpt from the previous plan remains accurate and warrants repeating in the current update:

Significant reorganization of hospital services will take place in the next few years. Planning and implementation of restructured hospital services in Niagara cannot be done in isolation. Long-term care facility, community service and other health care providers must be involved from the outset as full partners in the process.

The new "Joint Executive Committee" identified in the Health Services Restructuring Commission directions for Niagara will need to develop close links with the board of Community Care Access Centre (CCAC) Niagara. They will need to work together with the new region-wide Niagara Health System and with Hotel Dieu Hospital (now Hotel Dieu Health Sciences Hospital, Niagara) to establish the critical links and protocols needed to ensure essential in-home supports are in place prior to hospital discharge.

A staged planning process will avoid the confusion of attempting to do everything at once.

Reorganization of acute hospital services should aim to formally link networks of hospital services together with CCAC Niagara. Such an approach would facilitate the development of consistent, high quality, cost effective services in all communities in Niagara and be an important step towards the vision of a fully coordinated, seamless health system in Niagara.

The reconfiguration of Niagara's hospital system also includes the transfer of tertiary mental health beds/services from Hamilton (i.e., HPH, now St. Joseph's). Planning for this transfer, currently underway, involves significant linkages amongst hospitals long term care facilities and community agencies.

It is noteworthy in the context of this plan, given the significant needs/gaps in Niagara, that the Niagara Health System is exploring development of a regional Geriatric Assessment Program (which currently is available only at the Greater Niagara General site).

7.3 Links with Community Mental Health Initiatives

Planning for the development of community long-term care services is linked with planning for the development of community mental health services in the work of Council's Specialized Health Services for the Elderly Task Force released a discussion paper in November 1998 (ref: Moving Forward: Enhancing Specialized Assessment, Care and Treatment Services for Niagara's Elders).

This paper was followed by a Final Report in June 1999, entitled Moving Forward: Enhancing Specialized Assessment, Care and Treatment Services for Niagara's Elders - A Plan for Action. These documents urged the development and enhancement of specialized services for elders in Niagara with complex medical, functional, behavioural and/or psychiatric problems which:

- emphasize care delivery in the least restrictive setting
- minimize dislocation and environmental changes
- maximize cost effectiveness and quality of care by emphasizing critical mass and resource sharing
- promote accessibility by providing services locally.

In November 1999, Terms of Reference were approved for the Niagara Specialized Health Care for the Elderly Network Group with a mandate to provide collaborative leadership and support in the ongoing development and operation of coordinated, consistent, accessible, specialized assessment, care and treatment services for older adults throughout Niagara. (While this group is no longer supported financially by the DHC, staff have been invited to participate in the Network, on an ex-officio basis.)

Also, as described in Section 3, the two new Psychogeriatric Consulting Resource persons which will be joining the Niagara Geriatric Mental Health Outreach Team will play an important role in the development of networks and to the integration of mental health and long-term care services.

7.4 Ministry of Health and Long Term Care (MOHLTC) Restructuring

In addition to changing its name from the Ministry of Health to the Ministry of Health and Long-Term Care, the MOHLTC has undergone restructuring. Seven regional offices have been formed across the province. Niagara, along with Brant, Haldimand-Norfolk, and Hamilton-Wentworth come under the Central South Regional Office located in Hamilton. This office brings together into one decentralized office, responsibility for hospitals, long-term care and mental health care in these districts. This approach will hopefully promote greater service coordination and integration in future across the traditional silos.

7.5 Preschool Speech and Language/Healthy Babies/Healthy Children/School Health Support Services

The Speech Services Niagara Advisory Committee and the Healthy Babies/Healthy Children/Infant Education Parent Teaching Program Advisory Committee have formed a joint service planning subcommittee to enhance coordination, eliminate duplication and facilitate joint planning/implementation of new tasks/initiatives.

As well, a standard transition process has been developed by CCAC, NPCC and Preschool Services to transition children with multiple special needs into the School Board Junior and Senior Kindergarten programs and ensure access to School Health Support Services (SHSS).

Nonetheless, while a process is in place, gaps in treatment do occur; although children's treatment needs continue beyond preschool age, they end up on a waiting list due to a shortage of SHSS resources (see Section 6.13).

8 *RESPONSIVENESS TO CONSUMER NEEDS*

The purpose of this section is to identify provisions made to ensure service delivery will be sensitive to consumer needs and preferences, flexible and readily available.

8.1 Responsiveness to Consumer Needs

Implementation of the recommendations made in this plan and previous annual district service plans will help address the needs of consumers within Niagara. Section 2.2 of this plan includes a listing of significant needs of a variety of different population groups which are not well met in Niagara, as well, the previous section describes unmet service needs due to gaps in service (e.g., geriatrics, school health services).

8.2 Responsiveness to the Francophone Community

Welland and Port Colborne are designated areas under the *French Language Services Act*.

A summary of services available to the Francophone population includes:

- The Alzheimer Society provides caregiver support and counselling for Francophones caring for someone with dementia. Two bilingual counsellors offer a Francophone support group for caregivers.
- The Region's Community Services department provides in-home respite services in French as well as an Adult Day Program for Francophone seniors 3-days per week at Foyer Richelieu, a long-term care facility in Welland.
- With the assistance of Francophone volunteers, Meals-on-Wheels/Community Support Services (Welland/Pelham) offers meal delivery, congregate dining, friendly visiting and (escorted) transportation services in French.
- Community Care Access Centre (Niagara) provides in-take and case management services in French. Many of the professional services provided through CCAC Niagara are also available in French; a French Language telephone number has also been introduced by CCAC Niagara. A comprehensive French Language Service Designation Plan is being developed.
- Hospice Niagara has developed a Francophone program component for its volunteer recruitment and training related to visiting palliative care and bereavement support to serve

residents of Welland/Port Colborne. It has also collaborated with the Niagara Regional Palliative Care Organization to hire a French-speaking Program Coordinator.

- The Ontario March of Dimes provides personal support/attendant care/respite services in French to Niagara residents.
- The Canadian National Institute for the Blind has committed to hiring two French-speaking positions and has recently been successful in hiring an individual for its community liaison program.

Services provided through the Preschool Speech and Language Initiative are also available in Niagara in French through a French-speaking Speech Language Pathologist and Communications Development Assistant.

The Health Services Restructuring Commission final directions for Niagara indicate the new "Niagara Health System seek appropriate designation of its services in French to serve the needs of the Francophone population of Niagara." The Niagara Health System has developed a French Language Health Services Implementation Plan. The plan, which has been reviewed by the French Language Health Services Advisory Committee of the Niagara DHC, indicates work is in progress in this area.

8.3 Responsiveness to other cultural/linguistic groups

A number of agencies in Niagara report efforts to meet the needs of other cultural/linguistic groups in Niagara (e.g., use of interpreters, provision of culturally-specific diets). Seniors Community Programs of the Regional Municipality of Niagara has also developed an Adult Day Program in Niagara Falls that caters to the needs of the Italian population.

All these initiatives reflect the significant efforts to respond to consumer needs in Niagara.

9 FINANCIAL PLANNING AND COST-EFFECTIVENESS OF THE SERVICE DELIVERY SYSTEM

The purpose of this section is to identify how the plan helps to achieve a system of long-term care community service delivery which operates in an efficient and cost-effective manner by directing the appropriate amount of funding to services.

The identification of the outcome/impact of recommendations made in DHC plans for community long-term care services on the health needs of Niagara's residents has been identified in previous plans as a long-term goal. However, achievement of this goal, which would involve outcome measures at the system level, is dependent on the availability of data at the agency level. In an effort to facilitate monitoring and evaluation at the agency level, Niagara DHC linked with the Halton-Peel Task Force on the Evaluation of Long-Term Care Services, which was further ahead in its progress towards the same goal. This connection resulted in the involvement, in the latter part of 1998, of six Niagara agencies in the pilot evaluation of the "Draft Guidebook for the Evaluation of the Quality of Services Provided by Community-based Long-Term Care Agencies" which was developed in Halton-Peel. The six Niagara-area agencies who participated in the pilot are: Hospice Niagara, Canadian Red Cross transportation, Paramed Health Services, Alzheimer Society of Niagara, Brain Injury Community Re-entry and the Community Services Dept. of the Regional Municipality of Niagara.

Upon approval of the Guidebook by the Halton-Peel Evaluation Task Force in February 1999, it was distributed to all community long-term care agencies in Halton, Peel and Niagara. Although the MOHLTC did not officially endorse the Guidebook, many agencies report using it to assist them in meeting their monitoring and evaluation requirements.

The Proactive Emergency Services Proposal noted in previous sections will be evaluated to determine its effectiveness in alleviating Emergency Department pressures. This will at the same time afford an opportunity to assess and compare the pressures on the long term care system before and after implementation of the proposal.

Many agencies report improved data/computer systems but additional resources are required to support these initiatives. CCAC Niagara was involved in a province-wide computer system development project, which is now being implemented. They are also involved in the "Smart System for Health" project which will allow for transfer of information from one CCAC to another (e.g., to assist in accessing services for family members in other parts of the province).

APPENDICES

- Appendix A - Members of Council's Long-Term Care Advisory Committee, 2000-2001
- Appendix B - Selected demographic information from 1996 census
- Appendix C - Long Term Care Facilities/Beds
- Appendix D - Long Term Care Bed Ratios
- Appendix E - Summary of Niagara's Proactive Emergency Services Strategy
- Appendix F - Inventory of Community Long Term Care Services/Agencies

APPENDIX A

MEMBERS OF COUNCIL'S LONG-TERM CARE ADVISORY COMMITTEE November 2000

NAME	CATEGORY
BLAIS-BRETON, Jocelyne Co-ordinator, French Language Health Services	Other Provider (FLS)
BOOK, Ron Project Developer (Residential Hospice), Hospice Niagara	Provider (LTC)
CHISHOLM, Cathy Chief Executive Officer, Community Care Access Centre	Provider (LTC)
D'UVA, Camilla Registered Nurse, Geriatric Mental Health Outreach Program Niagara	Other Provider (Mental Health)
FARMER, Susan Permanent Charge Nurse, Continuing Care, Niagara Health System, St. Catharines General Hospital Site	Provider (Hospital)
GAGNÉ, Jocelyne (Chair) Regional Director, Ontario March of Dimes	Provider (LTC)
HANRATTY, Marguerite	Consumer
KELLY, Denise Program Supervisor, Central South Region Ministry of Health & Long-Term Care	Ex-Officio Other
Macdonald, Charlene Manager, School Aged Services and Clinics, Niagara Peninsula Children's Centre	Provider (LTC)
SCIARRA, Valerie	Consumer
SCOTT, Ronald (Interim Vice-Chair) Member, Niagara District Health Council	DHC
HOLMES, Julie Board member, Fort Erie Head Injury Association	Consumer Group
DARNAY, Julie, Senior Health Planner MANSON, Joanne, Senior Health Planner	DHC Staff

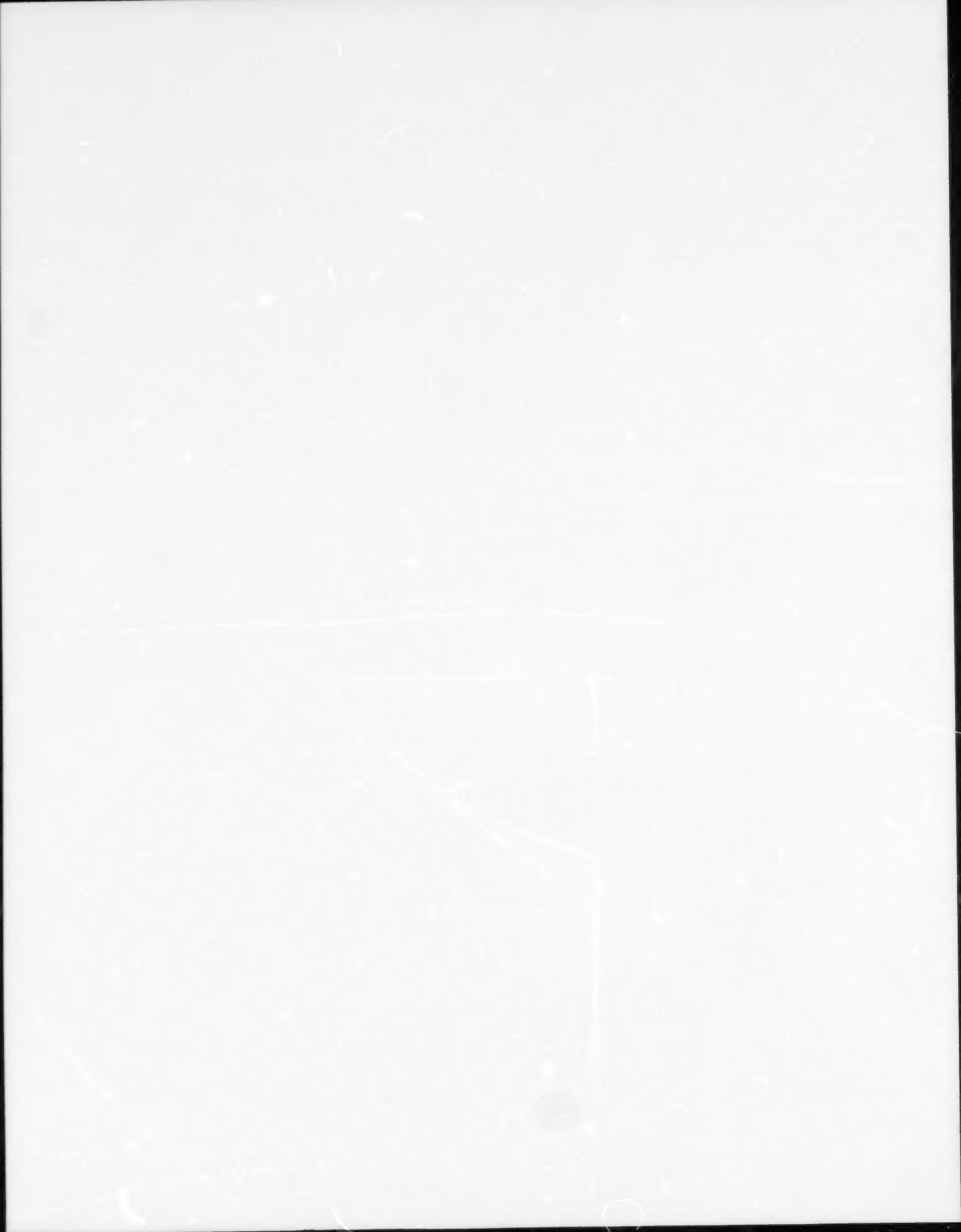
APPENDIX B

SELECTED DEMOGRAPHIC INFORMATION FROM 1996 CENSUS

**TABLE B1 – Distribution of Niagara's population by municipality.
All ages and ages 65+, 75+ and 85+**

Municipality	Population projected Year 2000				Percentage of total population		
	Total	65+	75+	85+	65+	75+	85+
(26065) Grimsby	20,960	2,873	1,313	366	13.7%	6.3%	1.7%
(26057) Lincoln	20,659	3,067	1,414	412	14.8%	6.8%	2.0%
(26021) West Lincoln	12,197	1,174	444	78	9.6%	3.6%	0.6%
Total, West Niagara	53,816	7,114	3,171	856	13.2%	5.9%	1.6%
(26053) St. Catharines	136,954	23,083	11,147	2,659	16.9%	8.1%	1.9%
(26037) Thorold	18,582	2,626	1,138	222	14.1%	6.1%	1.2%
(26047) Niagara-on-the-Lake	13,836	2,893	1,300	302	20.9%	9.4%	2.2%
Total, North Niagara	169,372	28,602	13,585	3,183	16.9%	8.0%	1.9%
(26043) Niagara Falls	79,702	13,278	6,105	1,373	16.7%	7.7%	1.7%
(26003) Fort Erie	28,793	4,912	2,256	507	17.1%	7.8%	1.8%
(26011) Port Colborne	18,734	3,756	1,701	400	20.0%	9.1%	2.1%
(26028) Pelham	15,454	2,226	951	184	14.4%	6.2%	1.2%
(26032) Welland	50,421	8,194	3,976	899	16.3%	7.9%	1.8%
(26014) Wainfleet	6,430	860	308	54	13.4%	4.8%	0.8%
Total, South Niagara	199,534	33,226	15,297	3,417	16.7%	7.7%	1.7%
Total, Niagara	422,722	68,942	32,053	7,456	16.3%	7.6%	1.8%
Ontario	11,697,065	1,479,071	658,237	160,098	12.6%	5.6%	1.4%

Source: Niagara DHC, 12/08/2000



APPENDIX B

SELECTED DEMOGRAPHIC INFORMATION FROM 1996 CENSUS

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All ages and ages 65+, 75+ and 85+**

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(26065) Grimsby	20,960	2,873	1,313	366	13.7%	6.3%	1.7%
(26057) Lincoln	20,659	3,067	1,414	412	14.8%	6.8%	2.0%
(26021) West Lincoln	12,197	1,174	444	78	9.6%	3.6%	0.6%
Total, West Niagara	53,816	7,114	3,171	856	13.2%	5.9%	1.6%
(26053) St. Catharines	136,954	23,083	11,147	2,659	16.9%	8.1%	1.9%
(26037) Thorold	18,582	2,626	1,138	222	14.1%	6.1%	1.2%
(26047) Niagara-on-the-Lake	13,836	2,893	1,300	302	20.9%	9.4%	2.2%
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(26003) Fort Erie	28,793	4,912	2,256	507	17.1%	7.8%	1.8%
(26011) Port Colborne	18,734	3,756	1,701	400	20.0%	9.1%	2.1%
(26028) Pelham	15,454	2,226	951	184	14.4%	6.2%	1.2%
(26032) Welland	50,421	8,194	3,976	899	16.3%	7.9%	1.8%
(26014) Wainfleet	6,430	860	308	54	13.4%	4.8%	0.8%
Total, South Niagara	199,534	33,226	15,297	3,417	16.7%	7.7%	1.7%
Total, Niagara	422,722	68,942	32,053	7,456	16.3%	7.6%	1.8%
Ontario	11,697,065	1,479,071	658,237	160,098	12.6%	5.6%	1.4%

Source: Niagara DHC, 12/08/2000

**TABLE B2 - Population aged 65+
Historical, current and projected size, by municipality**

Municipality	1996	1998	2000	Municipal share of 2000 population aged 65+	2003	2006	2011
Grimsby	2,681	2,866	2,873	4.2%	2,999	3,199	3,616
Lincoln	2,874	3,080	3,067	4.4%	3,187	3,303	3,604
West Lincoln	1,005	1,082	1,174	1.7%	1,308	1,426	1,686
West Niagara	6,560	7,028	7,114	10.3%	7,494	7,928	8,906
St. Catharines	22,208	22,637	23,083	33.5%	23,474	23,945	25,361
Thorold	2,441	2,492	2,626	3.8%	2,752	2,845	2,990
Niagara-on-the-Lake	2,721	2,825	2,893	4.2%	3,026	3,065	3,159
North Niagara	27,370	27,954	28,602	41.5%	29,252	29,855	31,510
Niagara Falls	12,542	12,954	13,278	19.3%	13,513	13,722	14,285
Fort Erie	4,605	4,784	4,912	7.1%	5,054	5,171	5,474
Port Colborne	3,625	3,677	3,756	5.4%	3,763	3,709	3,631
Pelham	1,944	2,090	2,226	3.2%	2,361	2,584	3,026
Welland	7,926	8,100	8,194	11.9%	8,253	8,430	8,928
Wainfleet	720	745	860	1.2%	944	999	1,180
South Niagara	31,362	32,350	33,226	48.2%	33,888	34,615	36,524
NIAGARA	65,292	67,332	68,942	100.0%	70,634	72,398	76,940

**TABLE B3 - Population aged 75+
Historical, current and projected size, by municipality**

Municipality	1996	1998	2000	Municipal share of 2000 population aged 75+	2003	2006	2011
(26065) Grimsby	1,167	1,279	1,313	4.1%	1,408	1,511	1,661
(26057) Lincoln	1,252	1,401	1,414	4.4%	1,533	1,638	1,782
(26021) West Lincoln	324	372	444	1.4%	531	600	724
Total, West Niagara	2,743	3,052	3,171	9.9%	3,472	3,749	4,167
(26053) St. Catharines	9,411	10,133	11,147	34.8%	12,026	12,570	12,759
(26037) Thorold	874	959	1,138	3.6%	1,297	1,425	1,516
(26047) Niagara-on-the-Lake	1,089	1,198	1,300	4.1%	1,456	1,567	1,654
Total, North Niagara	11,374	12,290	13,585	42.4%	14,779	15,562	15,929
(26043) Niagara Falls	4,932	5,454	6,105	19.0%	6,748	7,186	7,436
(26003) Fort Erie	1,833	1,990	2,256	7.0%	2,500	2,695	2,800
(26011) Port Colborne	1,441	1,547	1,701	5.3%	1,901	2,051	2,069
(26028) Pelham	706	810	951	3.0%	1,087	1,184	1,346
(26032) Welland	3,270	3,610	3,976	12.4%	4,306	4,517	4,511
(26014) Wainfleet	230	246	308	1.0%	344	425	518
Total, South Niagara	12,412	13,657	15,297	47.7%	16,886	18,058	18,680
NIAGARA	26,529	28,999	32,053	100.0%	35,137	37,369	38,776

Source: Derived from 1996 Statistics Canada Census Data, Niagara DHC, 12/08/2000.

**TABLE B4 – Projected population growth in Niagara,
by selected age groups 2000, 2003, 2006, 2011**

Age Group	2000	2003	% Change 2000- 2003	2006	% Change 2000- 2006	2011	% Change 2000-2011
0-14	77,168	73,769	-4.4%	69,934	-9.4%	65,556	-15.0%
<i>% of total</i>	18.3%	17.2%		16.2%		14.9%	
15-44	175,935	175,074	-0.5%	173,943	-1.1%	170,095	-3.3%
<i>% of total</i>	41.6%	40.9%		40.2%		38.8%	
45-64	100,677	108,313	7.6%	115,995	15.2%	126,215	25.4%
<i>% of total</i>	23.8%	25.3%		26.8%		28.8%	
65+	68,942	70,634	2.5%	72,398	5.0%	76,940	11.6%
<i>% of total</i>	16.3%	16.5%		16.7%		17.5%	
75+	32,053	35,137	9.6%	37,369	16.6%	38,776	21.0%
<i>% of total</i>	7.6%	8.2%		8.6%		8.8%	
85+	7,456	8,348	12.0%	9,899	32.8%	12,656	69.7%
<i>% of total</i>	1.8%	2.0%		2.3%		2.9%	
Total, all ages	422,722	427,790	1.2%	432,270	2.3%	438,806	3.8%

TABLE B2 - Population aged 65+
Historical, current and projected size, by municipality

Municipality	1996	1998	2000	Municipal share of 2000 population aged 65+	2003	2006	2011
Grimsby	2,681	2,866	2,873	4.2%	2,999	3,199	3,616
Lincoln	2,874	3,080	3,067	4.4%	3,187	3,303	3,604
West Lincoln	1,005	1,082	1,174	1.7%	1,308	1,426	1,686
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Fort Erie	4,605	4,784	4,912	7.1%	5,054	5,171	5,474
Port Colborne	3,625	3,677	3,756	5.4%	3,763	3,709	3,631
Pelham	1,944	2,090	2,226	3.2%	2,361	2,584	3,026
Welland	7,926	8,100	8,194	11.9%	8,253	8,430	8,928
Wainfleet	720	745	860	1.2%	944	999	1,180
South Niagara	31,352	32,350	33,239	48.0%	33,889	34,815	36,504
NIAGARA	65,292	67,332	68,942	100.0%	70,634	72,398	76,940

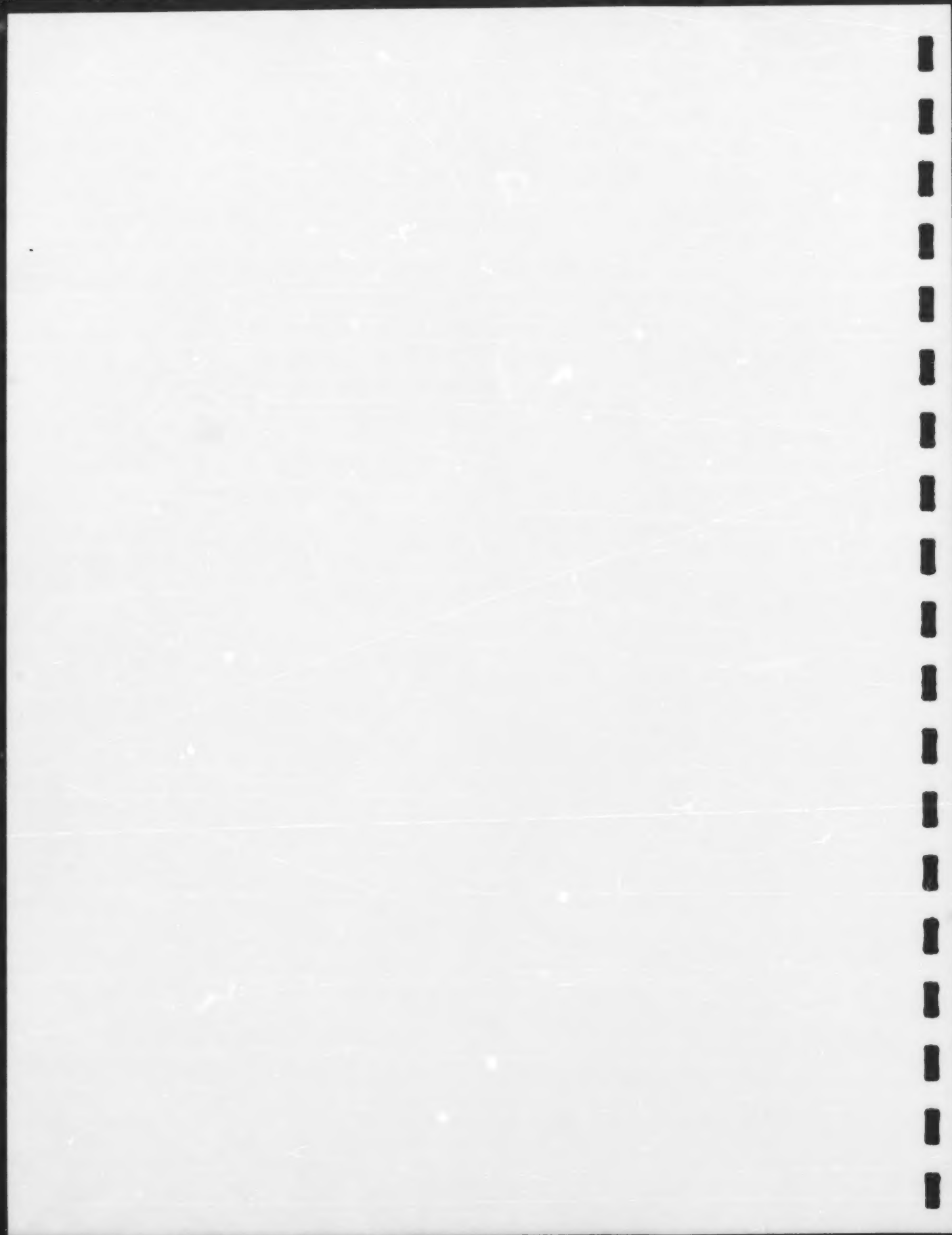
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Historical, current and projected size, by municipality

Municipality	1996	1998	2000	Municipal share of 2000 population aged 75+	2003	2006	2011
(26065) Grimsby	1,167	1,279	1,313	4.1%	1,408	1,511	1,661
(26057) Lincoln	1,252	1,401	1,414	4.4%	1,533	1,638	1,782
(26021) West Lincoln	324	372	444	1.4%	531	600	724
Total West Niagara	2,743	3,052	3,171	7.9%	3,472	3,749	4,167
(26053) St. Catharines	9,411	10,133	11,147	34.8%	12,026	12,570	12,759
(26037) Thorold	874	959	1,138	3.6%	1,297	1,425	1,516
(26047) Niagara-on-the-Lake	1,089	1,198	1,300	4.1%	1,456	1,567	1,654
Total North Niagara	11,374	12,290	13,585	42.4%	14,779	15,562	16,929
(26043) Niagara Falls	4,932	5,454	6,105	19.0%	6,748	7,186	7,436
(26003) Fort Erie	1,833	1,990	2,256	7.0%	2,500	2,695	2,800
(26011) Port Colborne	1,441	1,547	1,701	5.3%	1,901	2,051	2,069
(26028) Pelham	706	810	951	3.0%	1,087	1,184	1,346
(26032) Welland	3,270	3,610	3,976	12.4%	4,306	4,517	4,511
(26014) Wainfleet	230	246	308	1.0%	344	425	518
Total South Niagara	15,412	16,617	18,297	47.7%	18,800	19,858	18,680
NIAGARA	26,529	28,999	32,053	100.0%	35,137	37,369	38,776

Source: Derived from 1996 Statistics Canada Census Data, Niagara DHC, 12/08/2000.

**TABLE B4 – Projected population growth in Niagara,
by selected age groups 2000, 2003, 2006, 2011**

Age Group	2000	2003	% Change 2000- 2003	2006	% Change 2000- 2006	2011	% Change 2000-2011
0-14	77,168	73,769	-4.4%	69,934	-9.4%	65,556	-15.0%
% of total	18.3%	17.2%		16.2%		14.9%	
15-44	175,935	175,074	-0.5%	173,943	-1.1%	170,095	-3.3%
% of total	41.6%	40.9%		40.2%		38.8%	
45-64	100,677	108,313	7.6%	115,995	15.2%	126,215	25.4%
% of total	23.8%	25.3%		26.8%		28.8%	
65+	68,942	70,634	2.5%	72,398	5.0%	76,940	11.6%
% of total	16.3%	16.5%		16.7%		17.5%	
75+	32,053	35,137	9.6%	37,369	16.6%	38,776	21.0%
% of total	7.6%	8.2%		8.6%		8.8%	
85+	7,456	8,348	12.0%	9,899	32.8%	12,656	69.7%
% of total	1.8%	2.0%		2.3%		2.9%	
Total, all ages	422,722	427,790	1.2%	432,270	2.3%	438,806	3.8%



APPENDIX C

NIAGARA'S LONG-TERM CARE FACILITIES

MUNICIPALITY	FACILITY NAME	FACILITY TYPE	FUNDED BEDS	NEW * PERMANENT BEDS***	INTERIM BEDS
GRIMSBY	Deer Park Villa Kilean Lodge Shalom Manor	Nursing Home Nursing Home Nursing Home/ Charitable HFA	41 ** 50 132		
LINCOLN	Albright Manor United Mennonite	Charitable HFA Charitable HFA	231 80		
WEST LINCOLN			0		
ST. CATHARINES	Extendicare Heidehof Niagara Ina Grafton Gage Linhaven Tabor Manor Tufford Nsg Home Versa-Care Centre West Park Hlth Centre Cherry Hill	Nursing Home Charitable HFA Charitable HFA Municipal HFA Charitable HFA Nursing Home Nursing Home Nursing Home Nursing Home	152 106 40 226* 80 64 200 93	30*** 128	 2 41
THOROLD			0		
N.O.T.L	Chateau Gardens Heritage Place Upper Canada Lodge	Nursing Home Nursing Home Municipal HFA	124 36 80		4
NIAGARA FALLS	Dorchester Manor Oakwood Park Lodge R.H. Lawson Eventide Valley Park Lodge Cherry Hill Metro Capital Group	Municipal HFA Nursing Home Charitable HFA Nursing Home Nursing Home Nursing Home	98* 153 100 65	 160 160	
WELLAND	Foyer Richelieu Rapelje Lodge Sunset Haven Welland County Gen'l	Charitable HFA Municipal FHA Municipal HFA Nursing Home	62 118 227* 75		
PELHAM			0		
WAINFLEET			0		

MUNICIPALITY	FACILITY NAME	FACILITY TYPE	FUNDED BEDS	NEW * PERMANENT BEDS***	INTERIM BEDS
PORT COLBORNE	Northland Manor	Municipal HFA	87* ..		
FORT ERIE	Crescent Park Lodge Gilmore Lodge	Nursing Home Municipal HFA	68 80	96	
	TOTAL		2,868	574	47

Source: Ministry of Health and Long-Term Care Central South Regional Office, May, 2000/CCAC Niagara Feb 2001.

* With redevelopment of Regional Homes for the Aged, planning is in place for a 22-bed dementia care centre to be located at Linhaven but which will serve the entire region. Dorchester Manor will increase by 22 beds to 120; Sunset Haven will decrease by 107 beds to 120; and Northland Manor will increase by 63 beds to 150. The target for completion of the redevelopment is spring/summer 2002.

** Over bedded by 2 beds to March 2001.

*** Includes 100 beds approved in 1998 (not yet built) plus 474 of 480 beds announced in 1999 RFP (awarded May, 2000); balance of 72 beds announced in September 2000 to bring total new beds to 646 (preferred locations are Niagara Falls, St. Catharines, and Thorold); in November 1000, the 72 beds was revised upwards by 30 beds to replace beds which will not be built by Extendicare (i.e., those approved in the 1998 RFP); this brings the final allocation in Niagara to 102 beds.

Updated February 2001

APPENDIX D**EXISTING AND PLANNED LONG-TERM CARE BED /
POPULATION RATIOS IN NIAGARA REGION**

Municipality	Existing Beds Plus New Beds	Estimated Population Aged 75 & Over in 2000	Beds per 1,000 Population Aged 75 and Over in 2000 (after re-development of regional HFA- see note 7)
Grimsby	223	1,313	169.8
Lincoln	311	1,414	219.9
West Lincoln	0	444	0
Niagara-on-the-Lake	240	1,300	184.6
Niagara Falls	736	6,105	120.6 (124.2)
St. Catharines	1,089	11,147	97.7
Thorold	0	1,138	0
Fort Erie	244	2,256	108.2
Pelham	0	951	0
Port Colborne	87	1,701	51.1 (88.2)
Wainfleet	0	308	0
Welland	482	3,976	121.2 (94.3)
Niagara – Total	3,412	32,053	106.4

Notes:

1. Comparison by municipality of the ratio of existing and planned long-term care beds to the estimated population aged 75 and over within Niagara Region for the year 2000.
2. Existing beds include 70 new beds awarded by the MOHLTC in November 1998 (to be built in Niagara Falls); this number was originally 100 but 30 beds originally awarded in St. Catharines will not be built (see note 3 below) and 474 awarded in May 2000 (250 to be built in Niagara Falls; 128 in St. Catharines; and 96 in Fort Erie).
3. Balance of the total of 646 new beds for Niagara, approved as part of the MOHLTC initiative which will result in 20,000 new beds in the province by 2004, were announced in September 2000; **this balance was adjusted upward by 30 beds, from 72 beds to 102 beds in November 2000 to compensate for 30 beds awarded as part of 1998 RFP which will not be built;** preferred locations include Thorold, St. Catharines and Niagara Falls.
4. When all new beds are in place (target 2004) the ratio of beds per 1,000 population 75 and over will be 110.3 (assume reallocation of 23 beds lost due to the closure of the Nipponia Home in Vineland)
5. Currently 2,915 beds in operation (including 47 temporary and 2 ("over bedded") with corresponding ratio of 90.9 beds/1,000 population aged 75 and over.
6. The most recent provincial average available from the MOHLTC is 105.7 beds/1000 population aged 75 and over. It is not clear whether or not this is before or after the 1998 bed allocations; the updated ratio including the 1999 allocations is not available at this time.
7. The future development /redistribution of beds in the Regional Homes includes a 22-bed dementia care centre to be located at Linhaven but which will serve the entire region (hence the ratio for St. Catharines does not reflect these additional 22 beds after redevelopment); Dorchester Manor will increase by 22 beds to 120; Sunset Haven will decrease by 107 beds to 120; and Northland Manor will increase by 63 beds to 150. The target for completion of the redevelopment is spring/summer 2002.

APPENDIX E

OVERVIEW OF THE NIAGARA PROPOSAL TO THE MOHLTC FOR PROACTIVE EMERGENCY SERVICES STRATEGY

Background

According to trends being monitored throughout Ontario over the past several years, the incidence of ambulance by-pass situations (Critical Care Bypass and Redirect Consideration) has been escalating. Peaks in CCB and RDC most often occur in December and January. As outlined in the Report of the Niagara Ambulance By-pass Task Forces (October 1998), the causes and implications of CCB/RDC situations are multi-faceted and include factors related to the appropriateness of Emergency Department utilization, the availability of critical care and other inpatient beds, and the availability of long term care beds and community resources. These Emergency Department and systemic pressures have generated a great deal of attention and concern on the part of the public, the media and health care system providers throughout the province.

In August 2000, the MOHLTC announced an investment of more than \$100 million to address the potential pressures in Emergency Departments across Ontario this winter. The Ministry is striving to alleviate the anticipated Emergency Department stresses which typically escalate during the flu season. As part of this initiative, Niagara has been asked to develop a proposal to enhance Emergency Department coordination and to facilitate the timely discharge of patients from hospital.

The proposal includes requests for funding for the following positions and functions:

- an ER system co-ordinator - to ensure effective and efficient movement of patients across the continuum of hospital services from admission to timely discharge in order to minimize the utilization of CCB/RDC (Critical Care Bypass/ Redirect Consideration).
- Advance Practice Nurses - to liaise with and provide clinical consultation to LTC facilities in order to reduce transfers to emergency/hospital admissions and expedite discharges to LTC facilities;
- Long-Term Care facility staff-up fund - to support LTC facilities in extending their hours for new admissions and to care for higher intensity needs residents (e.g., with IVs, suctioning);
- an Education Co-ordinator - to educate LTC facility staff to provide extended treatments to residents of their facilities and to educate the public and physicians/office staff on the appropriate use of the Emergency (in conjunction with Public Health education on immunization);
- "On-call" hours for placement co-ordinators - to enable CCAC to initiate bed offer-placement services for LTC beds that become available after 4 p.m. Friday evenings and weekends and statutory holidays.

Non-funded initiatives being proposed include:

- Survey of long term care facilities and rest & retirement homes regarding capacity and capabilities (e.g., re: admission hours, overbedding, ability/requirements to care for higher needs residents, medical coverage).
- Promotion of exclusive use of RUGS classification system for patients in hospitals and residents in LTC facilities.
- CCAC to carry the costs of having its service provider staff start IV's in LTC facilities (with possible backup from Niagara Emergency Medical Service paramedics) .
- Absorption of some of the cost of educational and training activities, e.g.
 - Cost to LTC facilities of training of LTC Facility Directors of Care (or designates) in higher intensity treatments in a Train the Trainer model, and in implementing this model;
 - Cost to CCAC and hospitals of a joint effort to inform and educate hospital ER managers, off hours nursing staff and discharge planners about the daily availability of and access to CCAC services through CCAC Niagara's extended hours case manager team;
 - Cost to CCAC of cross-training extended hours case managers to continue bed placement processes begun by placement coordinators during regular working hours;
 - Cost to hospitals of inclusion of community partners in educational and quality initiatives.
- Increasing access to beds at Shaver Hospital site.
- Expanding of utilization programs (e.g. Interqual) to all hospitals/hospital sites
- Ensuring that a supply of medications and/or prescriptions accompanies patients discharged to LTC facilities on weekends.
- Taking under advisement by CCAC the suggestion that more flexible working hours and job duties be considered for case managers.

It is also being recommended to the MOHLTC that:

- LTC facilities need adequate funding to extend RN coverage.
- LTC facilities need more flexibility around approval for overbedding.
- CCAC needs changes to increase the provincially regulated limit on the amount of visiting personal support and nursing services available for people living at home.
- Payment options for rest and retirement homes accepting ALC patients need to be explored.
- The development of additional interim LTC beds in Niagara needs to be encouraged by supportive policy.

Summary prepared September 26, 2000.

Strategy approved by the Ministry of Health and Long-Term Care September 2000.

Implementation date November 2000.

APPENDIX F

NIAGARA LONG TERM CARE COMMUNITY SERVICES/AGENCIES FUNDED BY MINISTRY OF HEALTH AND LONG TERM CARE - 2000/2001

Adult Day Services (integrated frail seniors/Alzheimer/other dementia) : Regional Municipality of Niagara Senior Community Services Department

Attendant Care Outreach (adults with disabilities): Ontario March of Dimes

Behaviour Management Therapy/Psychological Services (ABI): Brain Injury Community Re-Entry; Anagram Premier

Caregiver Support, Training, Information and Education: Alzheimer Society; Regional Municipality of Niagara Senior Citizen's Department; VON Niagara

Caregiver Support, Respite: Regional Municipality of Niagara Senior Citizen's Department

Caregiver Support, Support and Counselling: AIDS Niagara; Alzheimer Society; VON Niagara

Caregiver Support, Volunteer Visiting: Hospice Niagara; Niagara-on-the-Lake Community Palliative Care Services; West Niagara Palliative Care Services

Children's School Health Support Services - Dietetics, Nursing, Occupational Therapy, Physiotherapy, Speech: CCAC Niagara

Children's Treatment Centre Services - Augmentative Communication, Occupational Therapy, Physiotherapy, Speech-Language Pathology, Social Work, Medical Services, Seating: Niagara Peninsula Children's Centre (on site services)

Friendly Visiting: AIDS Niagara; Alzheimer Society; Brain Injury Community Re-Entry; Ontario March of Dimes; Regional Municipality of Niagara Senior Citizen's Department; Meals on Wheels/Community Support Services; West Niagara Community Support Services*

Home Maintenance and Repair: Regional Municipality of Niagara Senior Citizen's Department; Meals on Wheels/Community Support Service; West Niagara Community Support Services*

Life Skills Services (ABI): Brain Injury Community Re-entry

Meals on Wheels: Meals on Wheels Fort Erie; Meals on Wheels Niagara Falls; Meals on Wheels Port Colborne; Meals on Wheels Thorold-St. Catharines; Meals on Wheels/Community Support Services; West Niagara Community Support Services*

Meals to Wheels/Congregate Dining: Meals on Wheels Niagara Falls; Meals on Wheels Port Colborne; Meals on Wheels Thorold-St. Catharines; Meals on Wheels/Community Support Services; West Niagara Community Support Services*

Pain and Symptom Management: Regional Palliative Pain and Symptom Management Services

Security Checks/Reassurance: Meals on Wheels/Community Support Services; Regional Municipality of Niagara Senior Citizen's Department; West Niagara Community Support Services*

Social Work (ABI): Brain Injury Community Re-Entry

Specialized Services for Blind and Visually Impaired: Canadian National Institute for the Blind

Specialized Services for Persons with Acquired Hearing Loss: Canadian Hearing Society

Supportive Housing (Elderly): Benevolent Society Heidehoff; Niagara Ina Grafton Gage Home for the United Church; Pleasant Manor; Regional Municipality of Niagara Senior Citizen's Department; Tabor Manor; United Mennonite

Supportive Housing (Physically Disabled Adults): Ontario March of Dimes; Tanguay Place

Supportive Housing (Acquired Brain Injury): Brain Injury Community Re-Entry; Anagram Premier

Supportive Housing (HIV/AIDS): AIDS Niagara

Supportive Living Service - ABI Outreach: CCAC Niagara, Brain Injury Community Re-entry

Transportation: Canadian Red Cross, Ontario March of Dimes, Meals on Wheels/Community Support Services

Visiting Homemaking: CCAC Niagara

Visiting Professional Services - Dietetics, Occupational Therapy, Physiotherapy, Speech-Language Pathology, Social Work - CCAC Niagara

*merged with Meals on Wheels/Community Support Services partway through fiscal year